Becky Wyland - Essential Therapy
2530 W 29th Ave,
Denver, CO 80211

COVID-19 Screening

In an ongoing effort to ensure patient safety, patients must complete this COVID-19 Screening prior to EVERY appointment.

In the past 14 days, have you experienced any of the following (select all that apply): *

- [ ] Fever or any temperature above 99.5 F
- [ ] Chills
- [ ] Shortness of breath
- [ ] Difficulty breathing
- [ ] Persistent chest tightness or pain in the chest
- [ ] Cough
- [ ] Sore throat
- [ ] Diarrhea
- [ ] Nausea
- [ ] Vomiting
- [ ] Headache
- [ ] Nasal congestion
- [ ] New onset body and/or muscle aches
- [ ] Fatigue
- [ ] Loss of sense of taste or smell
- [ ] Any signs of cold or flu
- [ ] Any other new onset illness
- [ ] Any worsening of existing illness/symptoms
- [ ] None of the above
- [ ] Others ____________________________

In the past 14 days, has anyone in your household or with whom you have had close contact experienced the following (select all that apply): *

- [ ] Fever or any temperature over 99.5 F
- [ ] Chills
- [ ] Shortness of breath
- [ ] Difficulty breathing
- [ ] Persistent chest tightness or pain in the chest
- [ ] Cough
- [ ] Sore throat
- [ ] Diarrhea
- [ ] Nausea
- [ ] Vomiting
- [ ] Headache
- [ ] Nasal congestion
- [ ] New onset body and/or muscle aches
- [ ] Fatigue
- [ ] Loss of sense of taste or smell
- [ ] Any signs of cold or flu
- [ ] Any other new onset illness
- [ ] Any worsening of existing illness/symptoms
- [ ] None of the above
- [ ] Others ____________________________

In the past 14 days, have you or anyone in your home been in close contact with someone with confirmed or suspected COVID-19? Close contact is defined as within 6 feet for 10 minutes or longer. *

- [ ] Yes
- [ ] No

In the past 14 days, have you or anyone in your home traveled? *

- [ ] Yes
- [ ] No

If yes to above, please indicate travel destinations and modes of transportation in the past 14 days:

- [ ] Within Colorado only
- [ ] Outside Colorado (within US)
- [ ] Internationally
- [ ] By plane
- [ ] By bus
- [ ] By train
- [ ] Others ____________________________

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In the past 14 days, have you or anyone in your home visited a care setting in which there were confirmed or suspected COVID-19 cases at the time or subsequently? *	☐ Yes	☐ No
I assert that all of the above information is accurate to the best of my knowledge. *	☐ Yes	☐ No
I agree to promptly notify my practitioner should I develop any cold or flu symptoms or suspected COVID-19 symptoms within 5 days of my treatment. *	☐ Yes	☐ No

PATIENT NAME * ____

PATIENT SIGNATURE : ____

Today's Date: ____