# J2 Therapy & Wellness

## Covid-19 Pre-Visit Screening

I, _____, knowingly and willingly consent to have physical and/or occupational therapy treatment performed during the Covid-19 pandemic. I also consent to wearing a face mask/covering to cover my nose and mouth at all times while in the clinic of J2 Therapy & Wellness.

**Within the past 14 days, have you experienced any of the following:**

| | | |
|---|---|---|
| Positive diagnosis for Covid-19 | YES | NO |
| Fever | YES | NO |
| Taken fever reducing medication past 24 hours | YES | NO |
| Shortness of Breath | YES | NO |
| Cough | YES | NO |
| Sore Throat | YES | NO |
| Fatigue | YES | NO |
| Muscle or body aches | YES | NO |
| Loss of taste or smell | YES | NO |
| Nausea or vomiting | YES | NO |
| Headache | YES | NO |
| Congestion | YES | NO |
| Runny nose | YES | NO |
| Travel outside the US in the last 2 weeks | YES | NO |
| Been in contact with a person confirmed with Covid-19 | YES | NO |
| Has anyone in your household had any of the above | YES | NO |

If you answered YES to any of the above, please explain: _____

_____

_____

I hereby acknowledge that my answers above are truthful and accurate. Furthermore, if I suspect that I have or I am diagnosed with Covid-19, I will contact our office with such information.

Signature _____ Date _____