COVID-19 Brief Questionnaire for New Patients

PLEASE ANSWER THE FOLLOWING QUESTIONS HONESTLY AND BRING THIS FORM WITH YOU TO YOUR APPOINTMENT.

PLEASE CIRCLE YOUR ANSWER AND FILL IN THE BLANKS BELOW.

1. Have you been out of the state in the past 3 months?	**YES**	**NO**
2. Have you ever been tested for COVID-19?	**YES**	**NO**
If you answered YES to the above question, when were you last tested?	**Answer:**	
What was the result of your test?	**NEGATIVE**	**POSITIVE**
3. Do you currently have any of the following symptoms? (circle all that apply or circle none)	**COUGH** **FEVER** **CHILLS** **COLD/SICK** **CHEST PRESSURE** **NONE**	

If you answered **YES** to Question #3 or **YES** to **all** the above questions, please contact our office to reschedule your appointment. By providing this office with the correct information, we can continue to help you and others in need of Chiropractic Care.

COVID-19 Pandemic Disclaimer:

- ☑ I understand that the global COVID-19 pandemic is ongoing and will be ongoing for the foreseeable future.
- ☑ I further understand that, despite numerous and reasonable precautions being taken to sanitize the office, tables, work benches, and counters, there is a chance I could be exposed to the COVID-19 virus while at the Chiropractic Center of New Britain, and that such exposure might cause me to contract the virus.
- ☑ I may at my own discretion ask my provider if my visit might be handled with a telehealth visit using special exercises or be reasonably delayed.
- ☑ I have decided that I wish to be seen in person at the Chiropractic Center of New Britain.
- ☑ I understand that upon entering I may have my temperature taken, be questioned, or examined regarding any other symptoms besides fever, and I may be denied entrance if medically prudent.
- ☑ I understand that I will be required to wear a mask at all times, unless lying face down on the tables, and to follow any other procedures deemed necessary by the facility in the interest of public safety.

The patient certifies that he/she has read and agreed to the forgoing, and is the patient, the patient's representative or is duly authorized by the patient as the patient's power of attorney to execute the above and accept its terms.

PATIENT Signature _____ Signature of GUARDIAN, if other than PATIENT _____ Date _____

PATIENT NAME – Please Print _____