

# Continental Psychiatric Services, PLLC

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## **Please circle your answers:**

Have you or anyone in your household had a sore throat, fever, cough, chills, body aches, shortness of breath, or loss of taste/smell in the last 21 days? **YES / NO**

Have you or anyone in your household been tested for COVID19? **YES / NO**

Have you or anyone in your household traveled outside of the US in the last 21 days? **YES / NO**

Are you or anyone in your household a healthcare provider or first responder? **YES / NO**

Have you or anyone in your household cared for anyone who has been in quarantine or is a presumptive positive/has tested positive for COVID19? **YES / NO**

Do you have reason to believe you or anyone in your household has been exposed to the COVID19 virus?  
**YES / NO**

To the best of your knowledge, have you or anyone in your household been in close contact with anyone who has tested positive for COVID19? **YES / NO**

Have you been vaccinated for COVID19? **YES / NO**

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_