



## COVID-19 Client Screening Questionnaire

\* Indicates a required field

Monarch Counseling  
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### Symptom Check

Have you or anyone in your household experienced any of the following symptoms in the last 21 days?

- \* **Fever over 100°F**
  - Yes
  - No
- \* **Cough**
  - Yes
  - No
- \* **Chills**
  - Yes
  - No
- \* **Sore throat**
  - Yes
  - No
- \* **Body aches**
  - Yes
  - No
- \* **Shortness of breath**
  - Yes
  - No
- \* **Loss of smell or taste**
  - Yes
  - No



## Lifestyle Questions

**\* Have you or anyone in your household been tested for COVID-19?**

- Yes, and I am awaiting test results
- Yes, and I have received the results
- No

**\* Have you or anyone in your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the last 30 days?**

- Yes
- No

**\* Have you or anyone in your household traveled within or outside of the U.S. in the last 21 days?**

- Yes
- No

**\* Have you or anyone in your household traveled on a cruise ship in the last 21 days?**

- Yes
- No

**\* Are you or anyone in your household a health care provider or emergency responder?**

- Yes
- No

**\* Have you or anyone in your household cared for an individual who is in quarantine or has tested positive for COVID-19 in the last 21 days?**

- Yes
- No

**\* Have you been in close proximity to any individual who tested positive for COVID-19 in the last 21 days?**

- Yes
- No



**\* Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19?**

- Yes
- No

**\* I agree that I have answered all of the above questions to the best of my knowledge.**

I consent to sharing information provided here.

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\* Patient or Guardian Signature

Date

Source: American Medical Association