Intake for Returning Clients

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Name: **Date:**

1. Have you or do you believe you have been exposed to COVID-19?

2. Have you travelled to or from a high risk area in the last 2-3 weeks?

3. What would you like to address in our session?

4. Please circle any of the following symptoms you may have experienced recently.

Shortness of breath
Respiratory infections
Vomiting
Nausea
Productive cough
Chills
Other:_____

Non-productive cough
Sore throat
Diarrhea
Fatigue
Fever
Headache

Client Signature: **Date:**