

ADVANCED CARE PHYSICAL THERAPY

246 RYDERS LANE, MILLTOWN, NJ 08850

TEL: 732-246-3585 FAX: 732-400-8474

PATIENT NAME:

DATE:

- Have you or anyone in your household had any of the following symptoms in the last 14 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever at or greater than 100 degrees Fahrenheit?
YES / NO
- Have you or anyone in your household been tested for COVID-19?
YES / 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 past 14 days?
YES / NO
- Have you or anyone in your household traveled in the U.S. in the past 14 days?
YES / NO
- Are you or anyone in your household a health care provider or emergency responder?
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
- To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19?
YES / NO

SIGN:

I UNDERTSAND THAT THE ALL STATEMENTS SHALL APPLY ANY TIME I VISIT ADVANCED CARE PHYSICAL THERAPY. IF ANY CHANGES, I WILL NOTIFY IMMEDIATELY.