FLOWING HEALTH at Ballard Wellness Clinic ~ 6204 8th Ave NW~ Seattle, WA 98107 ☎ 206.635.7704

SCREENING QUESTIONS/CONSENT TO TREATMENT DURING THE ERA OF COVID-19

Please circle yes or no:

I have traveled by air in the last 14 days. **YES** **NO**

I have been exposed to a confirmed COVID-19 person in the last 14 days. **YES** **NO**

I have experienced one or more of the following in the last 7 days: cough, fever, shortness of breath, flu-like symptoms. **YES** **NO**

I have been in close contact with someone in the last 7 days who was experiencing one or more of the following: cough, fever, shortness of breath, flu-like symptoms. **YES** **NO**

One or more of the following applies to me: YES NO*

I am in significant pain.
I am having significant dysfunction in my daily life or work due to my symptoms.
My symptoms are getting worse.
Without treatment today, my symptoms will likely get worse.

*If your answer is NO, we recommend you consider postponing your in-person appointment.

Although the clinic is taking as many precautions as possible to lower the risk of contracting COVID-19, I understand the risk is still there and I feel that my symptoms warrant treatment for today despite that risk. **YES** **NO**

Name:_____

Signed:_____ Date:_____

Below is for future dates (only sign once above if this is your first time filling out this form):

I attest that none of my above answers have changed. I will request a new form if they have.

Signed:_____ Date:_____

Signed:_____ Date:_____

Signed:_____ Date:_____

Signed:_____ Date:_____