Cantrell Chiropractic Inc.
2819 Crow Canyon Road, Suite 213
San Ramon, California 94583
(925) 854-2786 | CantrellChiro.com

CANTRELL
CHIROPRACTIC, INC.

Covid-19 Patient Screening Form

Instructions for use: These screening questions will be asked at the time your appointment is made and again within 1 hour of your appointment. Your temperature will be taken prior to entry to our office. Hand sanitizer will be provided upon entry and exit.

Patient/Parent/Guardian Names: ____

Screening questions	Date: / / Staff initial:____	Date: / / Staff initial:____	Notes
Do you have a fever or above-normal temperature (>100.4° F)? *Temperature at time of appointment: ___°F*	☐ No ☐ Yes	☐ No ☐ Yes	
Are you experiencing shortness of breath or having trouble breathing?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a dry cough?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a runny nose?	☐ No ☐ Yes	☐ No ☐ Yes	*If yes, please do not enter our facility.*
Have you recently lost or had a reduction in your sense of smell or taste?	☐ No ☐ Yes	☐ No ☐ Yes	*Your appointment will be rescheduled after 14 days.*
	☐ No ☐ Yes	☐ No ☐ Yes	
Are you experiencing chills or repeated shaking with chills?	☐ No ☐ Yes	☐ No ☐ Yes	
Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have unexplained muscle pain?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a headache?	☐ No ☐ Yes	☐ No ☐ Yes	

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Screening questions	Date: / / Staff initial:____	Date: / / Staff initial:____	Notes
Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	*If yes, please do not enter our facility. Your appointment will be rescheduled after 14 days.*
Have you been tested for COVID-19 in the last 14 days? *If "no," proceed to next question.*	☐ No ☐ Yes	☐ No ☐ Yes	
***If yes**, what is the result of the testing?* ***If negative,** proceed to next question.* ***If still waiting on results,** schedule appointment after results are known.*	☐ Negative ☐ Unsure ☐ Positive	☐ Negative ☐ Unsure ☐ Positive	*If positive, your appointment will be rescheduled after a negative test.*
Have you traveled more than 100 miles from your home in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	*If yes, please do not enter our facility. Your appointment will be rescheduled after 14 days.*

Patient signature required at appointment:

I agree to notify Cantrell Chiropractic Inc. if within 14 days I become ill with COVID-19 symptoms or test positive for COVID-19. I understand Cantrell Chiropractic Inc. has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 14 days.

Signature ____ Date __________