Aging Well PA, LLC

COVID-19 Health Screening Form

Applicant's name & PIA ID # _____

COVID-19 Screening	Initial		Pre-Visit	
	Yes	No	Yes	No
Are you or anyone you are living with experiencing any of the following symptoms? Fever (100+), cough, shortness of breath or difficulty breathing, diarrhea, chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell. If yes, what, when, and the steps taken to receive medical attention:				
Have you, someone with whom you have had contact, or anyone you have been living with been diagnosed with a positive test and/or by a health care practitioner for COVID-19?				
Have you or someone with whom you've had contact been asked to self-quarantine?				

_____ _____ _____

Staff signature Title Date