COVID-19: Protecting Each Other

Duke Chiropractic's priority is the health and safety of our patients, doctors, staff, and communities. To reduce the potential risk of exposure to and transmission of Coronavirus (COVID-19), we are requiring completion of a simple screening questionnaire for all visitors to our office. We also ask that you adhere to all COVID-19 related preventative measures in effect at our office. Thank you for your support in these measures to protect yourself, our doctors, our team members, and the community at large.

Patient Name:
Patient Contact Phone Number:

Patient Self-Declaration

If answer is "Yes" to ANY of the questions below, the patient will not be allowed on-site. We thank you for your understanding during these unique circumstances.

1.	Have you – or has anyone with whom you have had close contact in the last 14 days (roughly 6 feet or living in the same household) – <u>been diagnosed with COVID-19</u>? Yes ☐ No ☐
2.	Are you – or is anyone with whom you have had close contact in the last 14 days (roughly 6 feet or living in the same household) – <u>awaiting the results of a COVID-19 test</u>? Yes ☐ No ☐
3.	Has a public health official or healthcare provider told you – or anyone with whom you have had close contact in the last 14 days (roughly 6 feet or living in the same household) – that you/they are <u>suspected of having COVID-19 or should self-quarantine due to potential COVID-19 exposure(s)</u>? Yes ☐ No ☐
4.	Do you – or does anyone with whom you have had close contact in the last 14 days (roughly 6 feet or living in the same household) – have <u>COVID-19 or flu-like symptoms</u>, such as fever, cough, sore throat, or shortness of breath? Yes ☐ No ☐
5.	Within the last 14 days, have you – or has anyone with whom you have had close contact (roughly 6 feet or living in the same household) – <u>traveled</u> outside the United States and/or to an area within the United States with known COVID-19 community spread? Yes ☐ No ☐

Certification

I hereby confirm that my responses are true and correct. By completing and signing this form, I confirm to Duke Chiropractic that my presence at 9 East 38th Street, 9th floor will not knowingly put anyone at risk of exposure to COVID-19. I further recognize that the World Health Organization has declared a COVID-19 pandemic and that a national emergency has been declared related to the pandemic. I recognize, acknowledge, and accept the health risks of entering Duke Chiropractic's offices.

Patient signature_____ Date_____

Access to office Approved ☐ Denied ☐

Office administrator signature _____ Date_____