FLORIDA ATLANTIC UNIVERSITY

Communication Sciences and Disorders
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CLIENT SCREENING FORM

Name of Client_____ Date _____

Parent/Aide/Spouse _____ Relationship_____

The following questions must be answered by the parent, if child is under 18

	Pre-appointment	In-Office/**Day Of**
Do you/your child have fever, have felt hot or feverish in the last 14 days?	Yes No	Yes No
Are you/your child having shortness of breath or other difficulties breathing?	Yes No	Yes No
Do you/your child have a cough?	Yes No	Yes No
Any other flu-like symptoms such as gastrointestinal upset (diarrhea, nausea), headache, fatigue, or other abdominal (stomach) pain?	Yes No	Yes No
Have you/your child experienced any recent loss of taste, smell?	Yes No	Yes No
Have you/your child been in contact with any SUSPECTED OR CONFIRMED POSITIVE COVID-19 cases in the last 14 days?	Yes No	Yes No
Do you/your child have any history of heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders leaving them at higher risk of severe infection from coronavirus?	Yes No	Yes No
Have you/your child traveled in the past 14 days by bus, train, plane, or public transit?	Yes No	Yes No
Have you/your child traveled in the past 14 days to any regions affected by COVID-19?	Yes No	Yes No
Do **ANY** of the above questions apply to the guardian bringing the child in today or to any household member living with the child?	Yes No	Yes No
Has anyone in your household been diagnosed with COVID-19 in the last six months?	Yes No	Yes No

If you selected "yes" on any of these questions, please inform our staff, so we can have further discussions before admitting you/your child for services today.

I certify that all of the above information is complete and truthful.

Signature of client or guardian over 18 _____Date Today _____