NEBRASKA
MYOFUNCTIONAL SPECIALTIES

SUPPLEMENTAL HEALTH QUESTIONNAIRE

Thank you for your continued trust!
If you have been exposed to a communicable disease, you may spread the disease to the staff or other patients/parents in the practice. Therefore, prior to each appointment we will be asking the following questions to reduce the chances of transmission:

Have you been outside of the city or state in the last two weeks?
Yes _____ No _____
If yes, When and Where? _____

Have you, your child or others accompanying you to your visit or other recent acquaintances tested positive for or been diagnosed as having COVID-19, Influenza, or any other communicable disease?

Yes _____No_____ If yes, When? Date _____

Do you, your child, or others accompanying you or other recent acquaintances have:

A fever in the last week, or today? (Defined as 99.6 or above)? Yes_____ No_____

A cough? Yes_____ No_____

Shortness of breath and/or trouble breathing? Yes_____ No_____

Persistent pain, pressure, or tightness in the chest? Yes_____ No_____

Are you vaccinated for Covid-19? Yes_____ No_____
Are you vaccinated for influenza? Yes_____ No_____

I understand that if the answer to any of these questions is yes, I will be asked to reschedule, or the appointment may be conducted online to reduce transmission risks.

Signature_____ Date_____

As with the transmission of any communicable disease like the cold or flu, you may be exposed to COVID-19, at any time or any place. Be assured I have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite the careful attention to sterilization, disinfection and use of personal barriers, there is still a chance that you could be exposed to an illness in the office, just as you may at other places you travel. "Social distancing" has reduced the transmission, however, due to the nature of this therapy, it is not always possible to maintain a six-foot distance between the therapist and the client/patient.

Do you accept the risk and consent to therapy? Yes_____ No _____

Signature_____ Date_____

Child's name if applicable_____