



## COVID-19 BRIEF HEALTH QUESTIONNAIRE

Today's Date:	Program/Site:	
Client Name:	Client DOB:	Client Number:

***To help us ensure the safety of our clients and staff, please answer the following questions prior to entering the clinic:***

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|---|-------------------|------------------|
| <p>1. Have you or anyone in your household had any of the following symptoms in the last <b>21 days</b>?</p> <ul style="list-style-type: none"> <li>▪ sore throat</li> <li>▪ cough</li> <li>▪ chills</li> <li>▪ body aches for unknown reasons</li> <li>▪ shortness of breath for unknown reasons</li> <li>▪ loss of smell</li> <li>▪ loss of taste</li> <li>▪ fever at or greater than 100 degrees Fahrenheit</li> </ul> | <p><b>YES</b></p> | <p><b>NO</b></p> |
| <p>2. Have you or anyone in your household been tested for COVID-19?</p>  | <p><b>YES</b></p> | <p><b>NO</b></p> |
| If yes, date of test: _____   |                   |                  |
| <p>3. Have you or anyone in your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past <b>30 days</b>?</p>   | <p><b>YES</b></p> | <p><b>NO</b></p> |
| <p>4. Have you or anyone in your household traveled in or outside of the U.S. in the past <b>21 days</b>?</p>   | <p><b>YES</b></p> | <p><b>NO</b></p> |
| <p>5. Have you or anyone in your household traveled on a cruise ship in the last <b>21 days</b>?</p>  | <p><b>YES</b></p> | <p><b>NO</b></p> |
| <p>6. Are you or anyone in your household a health care provider or emergency responder?</p>  | <p><b>YES</b></p> | <p><b>NO</b></p> |

- |   |            |           |
|---|------------|-----------|
| 7. Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or that has tested positive for COVID-19? | <b>YES</b> | <b>NO</b> |
| 8. Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19?  | <b>YES</b> | <b>NO</b> |
| 9. To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19?                                       | <b>YES</b> | <b>NO</b> |

If you answered “yes” to one or more of these questions, please **CALL** your clinic to address your appointment and medication needs. If your visit is in regards to a psychiatric emergency, please contact **Crisis Services** at (530) 891-2810 or call 911.

For more information on COVID-19 Testing and other resources, please visit the Butte County Public Health website:

**<http://www.buttecounty.net/publichealth/>**