



Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Client No: \_\_\_\_\_

**SCREENING QUESTIONS:** Note: Answers may require rescheduling your procedure or service.

1. In the past 2 weeks I have had COVID with a Positive Test and Recovered. No \_\_\_ Yes \_\_\_
  2. In the past 2 weeks I have had close contact someone with COVID. Unknown/No \_\_\_ Yes \_\_\_
- Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Dr. Christian and Staff may wear masks if answers are Yes

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