Greenwich Center for Hope and Renewal
COVID-19 Screening Questionnaire

Name:_____. Contact number:_____

1. In the past 14 days have you had: Check all that apply:

    - Fever or chills
    - Unexplained muscle aches
    - Cough
    - Sore Throat
    - New onset of headache
    - New loss of taste or smell
    - Difficulty breathing or shortness of breath
    - None of the above

2. Have you been diagnosed with Coronavirus in the past 14 days?

    - Yes
    - No

3. In the past 14 days have you been within 6 feet of someone with suspected or confirmed Coronavirus?

    - Yes
    - No

4. Have you traveled in the past two weeks to a location that requires quarantine for 14 days?

    - Yes
    - No

If you answered yes to any of the questions above, you are not cleared to come to GCHR to work or for an appointment.

Client Signature:_____.
Date:_____