# Wellness Screening for Outpatient Clients

Client Name: ___________________________ Service Date: ___________________________

<table>
<thead>
<tr>
<th>Location:</th>
<th>Coon Rapids</th>
<th>Bloomington</th>
<th>Eagan</th>
<th>Eden Prairie</th>
<th>Minneapolis</th>
<th>Richfield</th>
<th>Woodbury</th>
<th>Collaborative Site:</th>
</tr>
</thead>
</table>

1. Has the client experienced any signs of illness such as fever, cough, shortness of breath, sore throat, muscle aches, fatigue, loss of taste or smell, and/or gastrointestinal problems of diarrhea, vomiting, or nausea in the last 10 days? □ Yes □ No

2. Has anyone living in the household experienced any signs of illness such as fever, cough, shortness of breath, sore throat, muscle aches, fatigue, loss of taste or smell, and/or gastrointestinal problems of diarrhea, vomiting, or nausea in the last 14 days? □ Yes □ No

3. Has the client had direct contact with someone with a confirmed diagnosis of COVID-19, or possible COVID-19 diagnosis within the last 14 days? □ Yes □ No

4. Has the person accompanying client to the appointment had direct contact with someone with a confirmed diagnosis of COVID-19, or possible COVID-19 diagnosis within the last 14 days? □ Yes □ No

By signing this document, I acknowledge that:

- The information provided above is accurate to the best of my knowledge
- I understand masks are required during the appointment and Fraser has the right to end the appointment if client and/or accompanying person are unable to comply with the requirement.

Person Answering Questions: ___________________ Relationship to Client: ___________________
Signature: ___________________________ Date: ___________________________