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FRASER A guiding star to navigate autism, mental health, and special needs at every stage of life.

Wellness Screening for Outpatient Clients

Client Name: _____ Service Date: _____

Location: ☐Coon Rapids ☐ Bloomington ☐Eagan ☐Eden Prairie ☐Minneapolis
☐Richfield ☐Woodbury ☐Collaborative Site:

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:_____