Behavioral Healthcare Corporation
Mental health for all we serve.

Pre-Appointment Medical Screening Questions

Client Name _____

Have you received a COVID-19 Vaccination? Y or N

Type of Vaccination _____ Date of Dose 1 _____ Date of Dose 2 _____

If two weeks post final dose, the following questions do not need to be asked. Temperature checks should be completed before every face to face interaction.

If you are reminding them of their appointment, please ask them to bring their vaccination record with them to their appointment. If you are seeing them face to face, please ask them for their vaccination record and make a copy for their file.

	Vaccination Card	Reminder ☐ **Appointment Reminder Call** **Date _____** **Staff _____**	Copy obtained ☐ **Face to Face Appointment** **Date _____** **Staff _____**
Have you in the last 10 days experienced any of the following flu-like symptoms? Gastrointestinal, upset stomach, headache, fatigue? Please list symptoms _____		☐ Yes ☐ No	☐ Yes ☐ No
Have you lost your sense of taste or smell? When _____		☐ Yes ☐ No	☐ Yes ☐ No
Have you had a fever of 100.4 or higher in the last 24 hours and had to take fever reducing medicine? Scheduling: Date of last fever 100.4 degrees or higher _____ Face to Face: Date of last fever 100.4 degrees or higher _____ Current temperature (face to face pre-appointment) _____		☐ Yes ☐ No	☐ Yes ☐ No
Have you been in contact with anyone confirmed with COVID-19? Date of contact _____		☐ Yes ☐ No	☐ Yes ☐ No
Have you had a COVID test? Date of Test _____ Neg. ___ Pos. ___ Pending ____		☐ Yes ☐ No	☐ Yes ☐ No

Signature _____ Date _____

822 Marietta Avenue, Lancaster, PA 17603
535 Locust Street, Columbia, PA 17512
PH: 717.399.8288 F: 717.399.8968