



COVID-19 CLIENT HEALTH QUESTIONNAIRE

Complete this form electronically and email it to jeff@mymobileassistant.org, or print and give to your driver

Do you have any of the following symptoms?

- Fever of 100.4 degrees Fahrenheit or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea
- Other (please describe) _____

In the past 48 hours:

Have you been in contact with anyone with COVID-19? Yes No

Have you been practicing social distancing (6ft apart), wearing a mask, washing hands etc. Yes No

Have you traveled outside of the DMV? Yes No

Has anyone visited you at your home or have you visited anyone at their home? Yes No

If yes, WHEN? _____

If yes, briefly describe HOW many people *and* HOW often? _____

Have you attended one or more social or other gatherings in excess of 10 people? Yes No

If yes, were you inside and/or out of doors

Do you employ a caregiver or housekeeper? Yes No

Are you able to enter and exit a vehicle with little or no assistance? Yes No

Are you able to walk on your own with little or no assistance? Yes No

Have you developed any new medical conditions since March 15, 2020? Yes No

Date: ___/___/___ Passenger Initials: _____ Driver Initials: _____