Paul Beljan, PsyD, ABPdN, ABN
Vanessa Berens, PhD
Casey Heinsch, MAS, LAMFT
Steve Quagliano, Autism Spclst
Chantel Osman, PsyD, Post-Doctoral Fellow

Beljan Psychological Services

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PATIENT SCREENING FORM

Patient Name:

	OFFICE VISIT
	DATE:
Do you or your child have a fever or have you/they felt hot or feverish recently? (14-21 days)	**YES / NO**
Are you/they having shortness of breath or other difficulties breathing? (14-21 days)	**YES / NO**
Do you/they have a cough?	**YES / NO**
Any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?	**YES / NO**
Have you/they experienced recent loss of taste or smell?	**YES / NO**
Have you/they been in contact with anyone confirmed postitive with COVID-19? (14-21 days)	**YES / NO**
Do you/they have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?	**YES / NO**
Have you/they traveled in the last 14 days outside of the country to regions affected by COVID-19?	**YES / NO**

Positive responses to any of these will likely indicate a deeper discussion with your practitioner before proceeding with services.

_____ _____

Patient/Guardian Signature **Date**