HISPANIC FAMILY COUNSELING, INC.
Orange/Seminole/Osceola
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Record #:

As concerns over the COVID-19 continue to grow, we are requesting that all clients complete this screening questionnaire. Your participation is essential to help us take precautionary measures to protect your health and everyone at Hispanic family Counseling Inc.

Client Name: _____

Therapist Name: _____

If the answer is "yes" to any of the following questions, the appointment cannot be rendered at the office. You have the option to complete the session via Telehealth or reschedule session after your quarantine (minimum 14 days from today). For Telehealth session, the Telehealth Consent **MUST** *be in file.*	
Have you or household family members returned from international or national travel within the last (14) days?	YES ☐ NO ☐
Have you or household family members had close contact with or cared for someone diagnosed with COVID-19 within the las (14) days?	YES ☐ NO ☐
Have you or household family members experienced any cold or flu-like symptoms in the las (14) days (fever, cough, sore, throat, respiratory illness, or difficult breathing)?	YES ☐ NO ☐
Do you authorize Hispanic Family Counseling to take your body temperature using a noninvasive thermometer? **	YES ☐ NO ☐

**If you refuse to authorize Hispanic Family Counseling to take your body temperature, it could be a reason to cancel your service and to reschedule it.

_____ _____
Client/Parent/Guardian Signature Date

_____
Parent Name – If applicable

_____
Witness Name

_____ _____
Witness Signature Date