



Speech, Occupational & Physical Therapy, PLLC

## CHATTY CHILD HEALTH SCREENING QUESTIONNAIRE

This questionnaire must be completed by ALL people entering into the treatment space, daily.

The answer to ALL questions must be "NO" to participate in any Chatty Child sessions.

Staff should remain at home if any of the responses are "YES"

Clients/parents/caregivers will NOT be permitted into the clinic, if any of the responses are "YES"

Since your last day of session/work/visitation have you had any of the following symptoms? Please check YES or NO.	YES	NO
Feeling feverish and/or having chills –documented temperature of 100.4°F or higher?		
Has there been any use of fever reducing medication within the last 3 days?		
A new cough that is not due to another health condition?		
New shortness of breath or difficulty breathing that is not due to another health condition?		
New chills that are not due to another health condition?		
A new sore throat that is not due to another health condition?		
New muscle aches that are not due to another health condition, or that may have been caused by a specific activity (such as physical exercise)?		
A new loss of taste or smell?		
Have you had a positive test for the virus that causes COVID-19 disease within the past 10 days?		
In the past 14 days, have you had close contact (within about 6 feet for 15 minutes or more) with someone with suspected or confirmed COVID-19?		
Have you recently travelled outside of New York State to a high risk state or country, or been in contact with someone who has travelled or been outside of New York State from a high risk state or country?		

Chatty Child staff retains the right to ask you to leave the facility should any of these symptoms present themselves in yourself, a caregiver, or your child during the course of treatment.

Child's Name	
Parent Name	
Parent Signature	
Date	