



CALIFORNIA DEPARTMENT OF
Mental Health

Coalinga State Hospital

QUESTIONNAIRE FOR VISITORS

Dear Visitor:

To help ensure the health and safety for both our individuals and staff, we ask that you complete the following questionnaire to indicate if you currently have any of the following conditions.

- | | | |
|--|----------|---------|
| 1. Fever | Yes_____ | No_____ |
| 2. Active cough | Yes_____ | No_____ |
| 3. Shaking chills | Yes_____ | No_____ |
| 4. Sore throat with or without swollen glands in your neck | Yes_____ | No_____ |
| 5. Unusual or severe headache or neck pain | Yes_____ | No_____ |
| 6. Loose or frequent stools (diarrhea) | Yes_____ | No_____ |
| 7. Vomiting | Yes_____ | No_____ |

If you have any of the above conditions, we encourage you to seek medical attention with your medical practitioner as soon as possible.

Print Name

Signature

Date

Once you have recovered, you may reschedule your visit.