Van Born Chiropractic Clinic P.C. COVID-19 Patient Screening Questionnaire

Patient Name: _____ D.O.B_____

Please check below if you are experiencing any of the following symptoms:

___ Cough ___ Shortness of Breath ___ Nausea/ Vomiting

___ Sore Throat ___ Body/Muscle Aches ___ Diarrhea

___ Chills ___ Loss of Smell or Taste ___ Loss of Appetite

Yes / No Do you have a fever (temperature over 100.3 F) without having taken any fever reducing Medications?

Yes/ No Do you have any reason to believe you have had exposure to COVID-19?

Patient Signature_____ Date_____

EMAIL:_____(If not already provided)