HUDSON FAMILY CHIROPRACTIC

& PHYSICAL THERAPY

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**COVID – 19 QUESTIONAIRRE**

1. Have you had a fever in the past 24 hours? Yes No
2. Have you been exposed to anyone who tested positive for covid-19 in the past 14 days? Yes No
3. Do you have symptoms of lower respiratory illness such as cough, shortness of breath, difficulty breathing, or a sore throat? Yes No
4. Have you experienced any recent loss of taste or sense of smell? Yes No
5. Have you had any recent stomach issues? (nausea, vomiting, diarrhea) Yes No
6. Are you a first responder, healthcare worker, or employee\attendee of a child or adult care facility? Yes No