China Acupuncture health center

Check List

1. Have you been diagnosed with or tested positive for COVID-19 in the last 30 days? Yes____No____
2. Have you been in contact with any person who has been diagnosed with/tested positive for COVID-19 in the last 21 days? Yes___No___
3. Are you feeling sick now with **ANY** flu-like symptoms such as

- Fever or feeling feverish Yes ___No ___
- Chills or repeated shaking with chills Yes ___No ___
- Muscle pain Yes ___No ___

- Cough Yes ___No ___
- Shortness of breath or difficulty breathing Yes ___No ___

- Headache combined with any flu-like symptoms Yes ___No ___
- Sore throat Yes ___No ___
- New loss of taste or smell Yes ___No ___

Explain here if you answered yes to any questions above: _____

_____

Please stay home if you answered yes to any questions above. Contact your PCP if you have high fever, difficulty breathing, or other severe symptoms. We will still provide you with Telehealth/Telemedicine services to support you.

Sign: _____ Date: _____

Type your name here as signature

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