Acupuncture Associates
Providing Happy Acupuncture

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COVID-19 QUESTIONNAIRE

1. Have you had the COVID-19 vaccine? ☐ YES ☐ NO
   a. If so, when was your last shot? _____
2. Have you tested positive for COVID-19 in the last 14 days? _____
3. Have you had exposure to COVID-19? _____
4. In the last seven days, have you had a temperature higher than 100.4°? _____
5. In the last seven days, have you had any of the symptoms the last 7 days? _____
   - ☐ a. Cough
   - ☐ b. Shortness of breath / difficult breathing
   - ☐ c. Fever
   - ☐ d. Chills
   - ☐ e. Muscle pain
   - ☐ f. Sore throat
   - ☐ g. New loss of taste or smell

6. Has anyone in your household experienced any of the above symptoms? _____
7. Have you been near someone who has tested positive for COVID in the last 14 days? _____
8. Have you been outside of your community in the last 10 days? _____
9. Have you been exposed to someone who has traveled outside of North Carolina in the last seven days? _____

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Parent / Guardian Signature: _____ **Parent / Guardian Name:** _____