



COVID-19 Screening Questionnaire

This must be completed and EMAILED to us before your 1st visit back to Lotus

You can revise then attach your completed form as a revised pdf, or print this form and after completing it, take a picture of it and attach that to your emailed response instead. Whichever is easier for you is great with us.

Thank you for your help!

Client Name: _____ **Date:** _____

Over the last 2 weeks, have you experienced ANY of the following? YES NO

Dry cough		
Fever (over 100° F)		
Shortness of breath		
Muscle aches (myalgias)		
Sore throat		
Headache (influenza-like illness)		
Fatigue		

Close Contact* YES NO

<p>Within the last 30 Days, have you been in <i>close contact</i> with anyone who has COVID-19, or is being monitored by the CDC for COVID-19?</p> <p><small>*Close contact = being at a distance of less than 6' from the person and for more than 10 minutes.</small></p>		
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Travel: Within the last 2 Weeks, have you... YES NO

<p>Traveled on a cruise ship or out of the country including to any US Territory?</p> <p>...OR...</p> <p>Traveled to any ANY* US State?</p> <p><small>*Except for the immediate region of: Connecticut, Delaware, New York, or Pennsylvania</small></p> <p>If "YES" to any of Travel Question: 10-Day Quarantine is REQUIRED upon return to New Jersey -- or -- 7-Day Quarantine with Negative Viral test results from test taken 3-5 Days upon return <small>(not an antibody test)</small></p>		
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