



COVID-19 Screening Questionnaire

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

You can revise/attach your 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:** _____

In 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		

Have you or anyone you are in close contact with... YES NO

Been in <i>close contact</i> with anyone who has COVID-19 or is being monitored by the CDC for COVID-19 in the last 30 days? <small>("Close contact" = being at a distance of less than 6' from the person and for more than 10 minutes.)</small>		
Traveled out of the country or travel on a cruise ship over the last 14 days? If "YES", where did you/they visit? _____.		
<p style="text-align: center;"><i>Please circle, underline or highlight all that apply:</i></p> <p>Traveled to any of the following 35 US States over the last 2 weeks? Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Guam, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, North Carolina, North Dakota, Oklahoma, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, or Wyoming ...OR... Traveled to ANY of these US States that have been removed from list but still have active 14-Day Quarantine windows upon returning to NJ? NJ Returns thru September 15th: California, Hawaii, Maryland, or Ohio</p>		