PATIENT DISCLOSURE

Please disclose any indication of having been exposed to COVID-19, or whether you hae experienced any signs or symptoms associated with the COVID-19 virus.

Patient's Name ____

Date ____

Do you have a fever? YES / NO

Do you have trouble breathing? YES / NO

Do you have a dry cough? YES / NO

Have you recently lost or had a reduction in your sense of smell? YES / NO

Have you been in contact with someone tested positive for COVID-19? YES / NO

Have you tested positive for COVID-19? YES / NO

Have you traveled outside the United States by air or cruise ship in the past 14 days? YES / NO

Have you traveled within the United States by air, bus, or train within the past 14 days? YES / NO

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Signature ____________________________ Witness ____________________________

Email ____

137 Main Street • Chester, NJ 07930 • 908.879.4020
www.bodyHeartTherapy.com