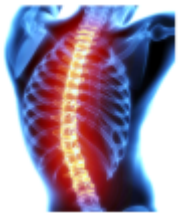

Carabasi Chiropractic Center

COVID-19 Self Health Check

EMERGENCY SYMPTOMS - Do you have ANY of the following (Check ALL that apply)

- ☐ Bluish lips or face
- ☐ Severe and constant pain or pressure in the chest
- ☐ Extreme difficulty breathing (such as gasping for air, being unable to talk without catching your breath, severe wheezing, nostrils flaring)
- ☐ New disorientation (acting confused)
- ☐ Unconscious or very difficult to wake upSlurred speech or difficulty speaking (new or worsening)
- ☐ New or worsening seizures
- ☐ Signs of low blood pressure (too weak to stand, dizziness, lightheaded, feeling cold, pale, clammy skin)
- ☐ Dehydration (dry lips and mouth, not urinating much, sunken eyes)

STOP - if you selected ANY of the emergency symptoms, CALL 911

CONTINUE -if you did not select any of the emergency symptoms

Within the last 10 days have you been diagnosed with COVID-19, had a test confirming you have the virus, or been advised to self-isolate or quarantine by your doctor or a public health official? *

- ☐ Yes
- ☐ No

In the last two weeks, were you within 6 feet of a COVID-19 infected person for more than a cumulative total of 15 minutes or more over a 24-hour period or have you had direct contact with infectious secretions (e.g., were coughed on)? *

- ☐ Yes
- ☐ No

In the last two weeks, did you live in the same house as someone who was confirmed to have COVID-19? *

- ☐ Yes
- ☐ No

Are you experiencing any of the following symptoms today? Choose all the apply. Leave empty if none of these apply to you.

- ☐ Fever or Chills
- ☐ Cough
- ☐ Shortness of Breath or Difficulty Breathing
- ☐ Fatigue
- ☐ Muscle or Body Aches
- ☐ Headache
- ☐ New Loss of Taste or Smell
- ☐ Sore Throat
- ☐ Congestion or Runny Nose
- ☐ Nausea or Vomiting
- ☐ Diarrhea

How old are you? *

- ☐ 0-4
- ☐ 5-19
- ☐ 20-44
- ☐ 45-64
- ☐ 65+

How many other people do you live with? *

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4 or more

Chronic Medical Conditions

- ☐ Chronic lung disease, such as moderate to severe asthma, COPD (chronic obstructive pulmonary disease), cystic fibrosis, or pulmonary fibrosis
- ☐ Serious heart condition, such as heart failure, coronary artery disease, or cardiomyopathy
- ☐ Weakened immune system or taking medications that may cause immune suppression
- ☐ Obesity
- ☐ Diabetes, chronic kidney disease, or liver disease
- ☐ Blood disorder, such as sickle cell disease or thalassemia
- ☐ High blood pressure
- ☐ Cerebrovascular disease or neurologic condition, such as stroke or dementia

- [ ] Smoking
- [ ] Cancer

Do you have any of the above severe underlying chronic medical conditions or other conditions that might put you at risk: *

- [ ] Yes
- [ ] No

How do you feel today?

Select the icon that best reflects your present state of mind *

- [ ] 5
- [ ] 4
- [ ] 3
- [ ] 2
- [ ] 1

Name

First Name Last Name

Signature

Today's Date

Month Day Year