Allison J. Scharf, DC

1. Have you had a fever in the last 24 hours of 100 degrees F or above? **yes or no**
2. Do you now, or have you recently had, any respiratory of flu symptoms (including fever, chills, sore throat, cough, muscle aches, or shortness of breath)? **yes or no**
3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? **yes or no**
4. Have you traveled anywhere outside of the state in the last two weeks **yes or no**

   Location_____
5. Have you had a new loss of sense of taste of smell? **yes or no**

Signature_____ Date_____