Generations Massages

Health Questioner

PLEASE PRINT LEGIBLY

Name_____

In The Last Two Weeks

Y N Have you had a fever? If yes how often?

_____

Y N Have you had a chills? If yes how often?

_____

_____

Y N Have you had a sore thought? If yes how often?

_____

Y N Have you had a muscle pain? If yes how often?

_____

Y N Have you had a cough? If yes how often?

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Y N Have you had a muscle pain? If yes how often?

_____

Y N Have you had loss of taste or smell? If yes how often?

_____

To the best of your knowledge have you come in direct contact with an infected person or persons? and of what was the virus?

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