NJPR
COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY

# COVID-19 Questionnaire

Full Name: _____ Date: _____/_____/_____

Phone Number: _____ Email: _____

| | |
|---|---|
| Have you been diagnosed with Coronavirus (COVID-19)? | _____Yes _____No |
| If diagnosed with Coronavirus (COVID-19), were you symptomatic? | _____Yes _____No |
| If diagnosed with Coronavirus (COVID-19) were you hospitalized? | _____Yes _____No |
| Has any member of your household been diagnosed with Covid-19? | _____Yes _____No |

I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature of Patient or Guardian: _____