LYDIAN CHIROPRACTIC
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LONG COVID – LONG VAX ADDENDUM

Name _____ **Date** _____

Please list dates of occurrences of COVID-19, duration of illness, and related symptoms.
Use an extra page to add further details if needed.

Date	Duration of illness	Symptoms

Did you take Paxlovid for any of these occurrences? Was it helpful? Did you have a negative reaction?

_____

_____

_____

Please list dates of any COVID vaccinations or boosters, and related symptoms (if any).
Please note the manufacturer of each, if you are able.

Date	Manufacturer	Reactions (if any)

Have you consulted any physicians, specialists or other practitioners regarding your diagnosis?
Please list.

Date	Physician Name	Specialty	Diagnoses and/or Recommendations