**COVID-19 HEALTH SCREENING FORM – PATIENT DISCLOSURES**

This patient disclosure form seeks information from you that we must consider before having an in person session.

A weak or compromised immune system (including but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at a greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to reconsider your appointment and have a Telehealth session.

|  |  |  |
| --- | --- | --- |
|   | Yes | No |
| Do you have a fever or above normal temperature? |   |   |
| Have you experienced shortness of breath or had trouble breathing? |   |   |
| Do you have a dry cough? |   |   |
| Do you have a runny nose? |   |   |
| Have you recently lost or had a reduction in your sense of smell? |   |   |
| Do you have a sore throat? |   |   |
| Have you been in contact with someone who has tested positive for COVID-19? If ye, what was the date?\_\_\_\_\_\_\_\_\_\_ |   |   |
| Have you tested positive COVID-19? If yes, what date did you test positive? \_\_\_\_\_\_\_\_\_\_\_\_\_ |   |   |
| Have you been tested for COVID-19 and are awaiting results? |   |   |
| If you have COVID-19, how long have you been symptom free?  | Date:\_\_\_\_\_\_\_\_\_ |
| Have you traveled outside of the United Stated by air or cruise ship in the past 14 days? |   |   |
| Have you traveled within the United states by air, bus or train within the last 14 days? |   |   |

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By singing this document, I acknowledge that the answers I have provided are true and accurate.

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Patient Name Patient Signature (parent if minor) Date

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Witness