



Asheville Physical Therapy

Orthopedics • Sports Medicine • Sports Performance

Covid - 19 Pandemic - Patient Disclosures

This patient disclosure form seeks information from you, (the patient/ or custodian) which we must consider before making treatment decisions in circumstances of the COVID-19 virus.

In order to protect you, our staff, and others, this form completion is imperative, so that Asheville Physical Therapy, (APT) can be aware of each patient's overall health, and follow CDC and Buncombe County recommendations / guidelines, especially in consideration of COVID -19.

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

	YES	NO
Do you have a fever or above normal temperature?		
Have you experienced shortness of breath or had unexplained, recent trouble breathing?		
Do you have a dry cough, runny nose, sore throat or flu like symptoms ?		
Have you recently lost or had a reduction in your sense of smell?		
Have you been in contact with someone who has recently (in last 2 wks), tested positive for COVID-19?	Date: _____	
Have you tested positive for COVID-19?	Date: _____	
Have you been tested for COVID-19 and are awaiting results?	Date: _____	
Have you traveled within the United States by air, bus, or train within the last 14 days?		
Have you traveled outside the United States by air or cruise ship, in the last 14 days?		

I fully understand and acknowledge the above information and have disclosed this information to my healthcare provider/ staff at APT, who are essential workers and working to provide needed care, in the midst of this COVID – 19 pandemic.

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

Patient or Custodian

Date

Witness

Temperature