Adams County Health Department Covid-19 Self-Assessment Tool

Name: _____ DOB: _____ Married: Yes / No

Parent Name (if minor): _____ *Parental Consent:* Signature _____

Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Email: _____

Do you prefer to be contacted via text or email? _____

Health Assessment

Did you ever have symptoms? Yes / No

Do you have symptoms today? Yes / No

Date symptoms started (if yes): _____

Have you seen a doctor: Yes / No

Other symptoms or health conditions?

_____

Tracing

Have you been in contact with anyone who has tested positive for COVID? _____

Symptoms Experienced?

Abdominal Discomfort		Headache	
Chills		Loss of Taste or Smell	
Chest Pain/Tightness		Muscle Aches	
Cough		Rash (describe if yes)	
Shortness of Breath		Rigors	
Diarrhea		Sore Throat	
Fatigue		Runny Nose	
Feverish		Vomiting	
Measured Temp		Other (write to left)	

Have you been to any of the following (list date and location) **Go back 2 weeks – This helps us identify outbreaks.**

Medical/Dental	Church	Shopping/Dining	Gatherings/Weddings/Other

Employer / School

Name of Organization	Dates / Times	Known Close Contacts *List on back of form*	Note Needed?
		Yes / No	
		Yes / No	
		Yes / No	

Additional Notes:

_____

For Official Use Only

Result: Positive _____ Negative _____ **Data Entered By: _____**

Notified By: _____ **Data Entry Date/Time: _____**

Notified Date/Time : _____ **Case Worker: _____**

Patient Name: _____

Contacts

Please list any individual you may have been in close contact with within 48 hours prior to symptoms. If you test positive but have not had symptoms, go back 48 hours from the date of your positive test. (close contact means less than 6 feet apart for more than a few minutes)

Name of person in your household	Direct Contact Phone Number if household member is over 18 years	Household Contact Date of Birth	Does your household member have symptoms	Has this person tested positive for COVID

Name of contact outside of household	Phone Number of Contact	Location of Contact	First Day of Contact (no further back than 48 Hours from your symptoms)	Most recent date of Contact

Additional Contact Notes: _____

_____

_____

_____

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