Harbour Healthcare, Inc.

719 High Street, Suite 118
Portsmouth, VA 23704
(PHONE) 866.601.4443 (FACSIMILE) 866.596.6056
www.myharbourhealthcare.com

Name: _____ **Nickname or preferred:** _____ **Date:** _____/_____/_____

Registration: Workers Compensation

If you have not yet filed a claim, go to http://www.vwc.state.va.us/forms/claim-form and contact your employer before beginning care.

- **Address/City-State-Zip**: _____
  Phone: ( ) - _____-_____ **Cell Phone**: ( ) - _____-_____
  Preferred email: _____@_____._____
  SS# or Legal ID: _____ **Birthday**: ___/___/_____ **Age**: ____
  Marital Status (circle):
  ☐ Single ☐ Partner ☐ Married ☐ SO ☐ Separated ☐ Divorced ☐ Widow(er)
- **My preferred contacts are:**
  ☐ Home ☐ Work ☐ Cell/Mobile ☐ eMail ☐ Spouse ☐ Mail ☐ All
- **Work information/Occupation:** _____
  Occupation/Position: ☐ FT ☐ PT ☐ Disabled ☐ Retired ☐ Unemployed
  Employer: _____
  Work Address/City State Zip: _____
  Work Phone: _____
- **Family:**
  Spouse name: _____ **Contact Information is:** ☐ Same ☐ Different
  (If different) Address/City State Zip: _____
  Occupation/Position: _____
  ☐ FT ☐ PT ☐ Disabled ☐ Retired ☐ Unemployed
  Children names:
  Name: _____ ☐ M ☐ F Age: ____ **Name:** _____ ☐ M ☐ F Age: ____
  Name: _____ ☐ M ☐ F Age: ____ **Name:** _____ ☐ M ☐ F Age: ____
  If spouse is the primary insured, please complete **Spouse DOB**: ____/____/_____
- **Employer**: _____
  Work Address/City State Zip: _____
  Work Phone: _____-_____-_____ **Spouse's birthday**:_____/_____/_____
  I am a ☐ guardian ☐ power of attorney ☐ N/A (not applicable)
- **Emergency Contact**: **Name**: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. _____
  Phone: (_____)_____-_____ Relationship: _____
- **Financial responsibility**

(all payments are due at the time of service unless other arrangements have been made in advance)

BRING YOUR ID AND INSURANCE WITH YOU TO THE VISIT

Who is responsible for payment and how?

☐Self-Cash/Check/CC ☐Employer ☐Lien ☐Power of Attorney ☐Insurance

I, Print name, certify that the information provided on this form, and providing to on any subsequent information with Harbour Healthcare, is true to the best of my knowledge.

(sign) at office _____ ***(witness) at office*** _____

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- Please indicate **the type of incident** you were involved in (circle one):
  ☐ In Office ☐ Driving ☐ Lifting ☐ Bending ☐ Hit ☐ Fell ☐ Other _____
- **Date of Injury (DOI):** / / **Time:** _____:_____ AM / PM
- Please explain **exactly how the injury occurred:**
  _____
- Name and contact information for **immediate employer**:
  Name: _____
  Position: _____
  Phone: _____-_____- _____
- Was your supervisor **notified prior to filing a claim**? ☐ Yes / ☐ No / ☐ Unsure
- **Pre-authorization has been granted in writing by:**
  Name: _____
  Position: _____
  Date of pre-authorization: _____/_____/_____
- Have you received a referral specifically for chiropractic care from your immediate supervisor? ☐ Yes / ☐ No / ☐ Unsure
- Was a **police report filed**? ☐ Yes / ☐ No / ☐ Unsure
  Report number and state (if applicable): _____
- **Were other people involved**? ☐ Yes / ☐ No / ☐ Unsure
  If others, please list names and relationships: _____
- **As a result of the injury**:
- **Have you lost any time from work?** ☐ Yes ☐ No If so, how much? _____
- **Have you already seen a medical physician (M.D./D.O.)** ☐ Yes ☐ No
- **Where did you go** after the injury (please circle)?
  ☐ Sent ☐ Drove to ☐ Drove home myself ☐ Driven home by _____
  ☐ Walked ☐ Went _____
- Were any **tests** done? ☐ Yes ☐ No
  ☐ Exam ☐ X-ray ☐ MRI ☐ CT scan ☐ PET scan ☐ Other _____ ☐ None
- Were medications prescribed at that time? ☐Yes ☐No
  If yes, what was prescribed? _____
- Did you follow the recommendation? ☐ Yes ☐ No
  If yes, did your follow through either way help? ☐ Yes ☐ No

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As a result of the injury, have you experienced any of the following:

- ☐ Dizziness
- ☐ Memory loss
- ☐ Blurry vision
- ☐ Tension
- ☐ Fatigue
- ☐ Bodily pain
- ☐ Stiff neck
- ☐ Stiff back
- ☐ Nausea
- ☐ Numbness
- ☐ Tingling
- ☐ Jaw problems
- ☐ Sleep disturbed
- ☐ Ears ringing
- ☐ Forgetfulness
- ☐ Short of breath
- ☐ Headaches
- ☐ Other

_____

Please describe any other pertinent events or information related to the injury:

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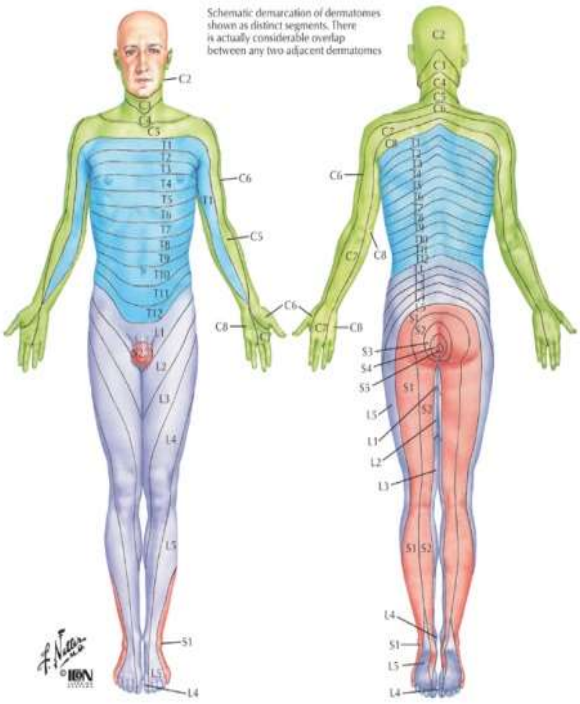
Please draw with an X all areas affected or you would like to discuss with the doctor, and please be AS DESCRIPTIVE AS POSSIBLE (sharp, dull, achy, 'like a knife', etc.)



Levels of principal dermatomes

C5	Clavicles
C5, 6, 7	Lateral parts of upper limbs
C8, T1	Medial sides of upper limbs
C6	Thumb
C6, 7, 8	Hand
C8	Ring and little fingers
T4	Level of nipples
T10	Level of umbilicus
T12	Inguinal or groin regions
L1, 2, 3, 4	Anterior and inner surfaces of lower limbs
L4, 5, S1	Foot
L4	Medial side of great toe
S1, 2, L5	Posterior and outer surfaces of lower limbs
S1	Lateral margin of foot and little toe
S2, 3, 4	Perineum

Office Use Only:
Patient accepted for care?

Initials: