HARBOUR HEALTHCARE
711 Court Street Portsmouth, VA 23704
(PHONE) 866.601.4443 (FACSIMILE) 866.596.6056
www.myharbourhealthcare.com

Name: **Preferred/Nickname:** **Date:**

Registration

Address/City-State-Zip: _____

Home Phone: _____ **Cell Phone:** _____

eMail: _____

SS# or Legal ID: _____ **Birthday:** _____ **Age:** _____

Marital Status (Mark X as applicable):

Single ☐ **Partner** ☐ **Married** ☐ **"Significant Other"** ☐

Separated ☐ **Divorced** ☐ **Widow(er)** ☐

My preferred contacts are:

☐ **Home** ☐ **Work** ☐ **Cell/Mobile** ☐ **eMail** ☐ **Spouse** ☐ **Mail** ☐ **All**

Work information: ☐ **FT** ☐ **PT** ☐ **Retired** ☐ **Unemployed** ☐ **Disabled**

Occupation/Position: _____ Employer: _____

Work Address/City State Zip: _____

Work Phone: _____

Emergency Contact:

Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. _____

Phone: _____ **Relationship**: _____

If spouse is the primary insured, please complete
Spouse DOB: _____
Spouse Employer: _____ **Work Address/City State Zip**: _____
Work Phone: _____

Family: ☐ N/A **Children names**:

Name: _____ ☐ M ☐ F ☐ X Age: ___ **Name**: _____ ☐ M ☐ F ☐ X Age: ___
Name: _____ ☐ M ☐ F ☐ X Age: ___ **Name**: _____ ☐ M ☐ F ☐ X Age: ___

Name / contact number of PCP: _____

Name / contact number of Specialists: _____

Financial responsibility:

ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE

☐ Self-Cash/Check/CC ☐ Insurance

☐ Power of Attorney ☐ Employer (Workers Comp) ☐ Lien (Personal Injury)

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Name: **Preferred/Nickname:** **Date:**

Chief Concerns

Issue 1

- LOCATION (where in the body): _____
- WHEN (or approximately when) did this issue occur? _____
- HOW did this happen? _____
- How would you characterize this problem? Please describe in terms of
    - QUALITY (sharp, piercing, etc.): _____
    - INTENSITY (0-10 scale with zero= no symptom and 10= a 'worst ever) _____
    - Have/Are you had any numbing or tingling in this area? ☐ Yes ☐ No
    - How long does this issue last (minutes, days, inly in the morning, etc.)

      _____
    - Has anything made it better or worse? _____
    - How is this affecting your daily activities?

      _____
- What **type(s) of care** have you received for this issue?

☐ Medical ☐ Chiropractic ☐ Physical Therapy ☐ Personal Trainer/Exercise Physiologist ☐ Other

- What type of tests have been performed (please include where and when)?

  ☐ X-rays ☐ MRI ☐ CT ☐ CAT Scan ☐ Other _____

Issue 2

- LOCATION (where in the body): _____
- WHEN (or approximately when) did this issue occur? _____
- HOW did this happen?
- How would you characterize this problem? Please describe in terms of
    - QUALITY (sharp, piercing, etc.): _____
    - INTENSITY (0-10 scale with zero= no symptom and 10= a 'worst ever) _____
    - Have/Are you had any numbing or tingling in this area? ☐ Yes ☐ No
    - How long does this issue last (minutes, days, inly in the morning, etc.)

      _____
    - Has anything made it better or worse? _____
    - How is this affecting your daily activities?

      _____
- What **type(s) of care** have you received for this issue?

☐ Medical ☐ Chiropractic ☐ Physical Therapy ☐ Personal Trainer/Exercise Physiologist ☐ Other

- What type of tests have been performed (please include where and when)?

  ☐ X-rays ☐ MRI ☐ CT ☐ CAT Scan ☐ Other _____

If more than two issues or requires more explanation, please continue here or let us know and will provide an additional page format:

_____