HARBOUR HEALTHCARE
711 Court Street
Portsmouth, VA 23704
866-601-4443
www.myharbourhealthcare.com

Update Form

(to be completed PRIOR to seeing the doctor)

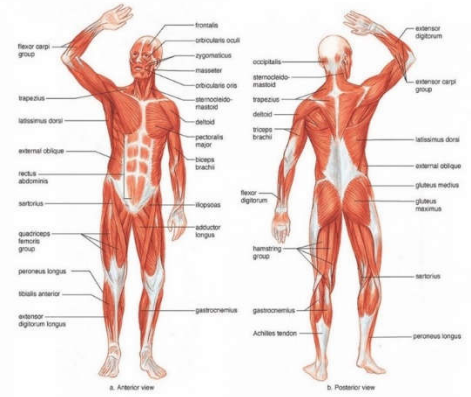
Patient Name: **Phone:**

Are you a Medicare patient? ☐ **Yes** ☐ **No** **Did you have a car accident?** ☐ **Yes** ☐ **No**

Is this a *new injury* or *flare-up of an old injury*?

What happened and When did it happen?

Where? Mark all areas and describe



How would you characterize the quality? (sharp, dull, achy, burning, stabbing, etc.)

How would you rate the duration of the pain (or problem), both at this moment and when it first began?

On a scale of 1-10 (1= mild and 10= the most severe) or as mild, mild-moderate, etc.
in the (specific part of body)
in the (specific part of body)
in the (specific part of body)
Has anything helped/hurt (made it better or worse)?

Signature/Date: