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)

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

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 _____

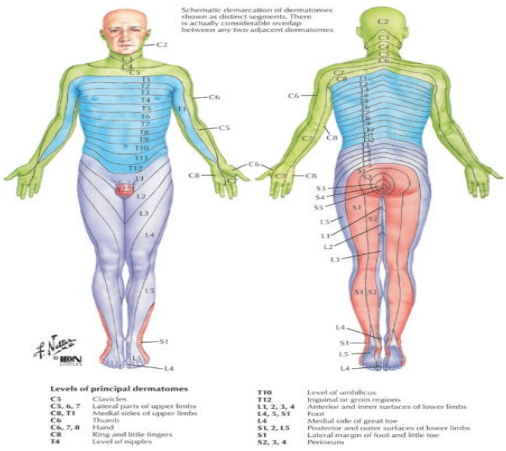
If more than two issues or requires more explanation, please continue here or let us know and will provide an additional page format:

_____

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

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

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



Family History

Key:

M = Mother MGM = Maternal Grandmother PGM = Paternal Grandmother
F = Father MGF = Maternal Grandfather PGF = Paternal Grandfather
B/S =Brother/Sister

	Living (Y/N)	**Age**	**(If Deceased age of passing and reason)**
M			
F			
MGM			
MGF			
PGM			
PGF			
B/S			
B/S			
B/S			

Has anyone in your family been diagnosed with (YES / NO: if yes please explain):

Alzheimer's? _____
Autoimmune disease (specify)? _____
Cancer? _____
Diabetes? _____
Heart Disease? _____
High Blood Pressure? _____
High Cholesterol? _____
Kidney Disease? _____
Mental Issues or Addiction? _____
Stroke? _____
Other not mentioned? _____

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

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

Comprehensive Review Of Systems

Any questions you feel uncomfortable answering or to discuss confidentially, please mark with a "Z" in details field

GENERAL OVERALL:

How would you rate your attention to:

Diet? Exercise?

Stress? _____ Mental Health/Well Being?

SOCIAL HISTORY:

Describe a typical day regarding work/diet/recreation and if anything is impeded by pain/disease:

Please include all medications AND supplements/vitamins AS WELL AS over-the-counter medications?(a separate form is available if needed)

MEDICAL/SURGICAL/PROCEDURE HISTORY:

HAVE YOU HAD OR BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

Please check YES Or NO and if YES please provide as much detail as possible (i.e. dates/years)

MUSCULOSKELETAL

Pinpoint deep pain in or near a bone? _____
Joint swelling anywhere in your body? _____
Pain in any extremities (not in your spine)? _____

EYE/EAR/NOSE/THROAT (EENT)

Pain or dryness in or around your eyes? _____
Visual disturbances? _____ Blurry/loss of vision? _____ Ringing in your ears (Tinnitus)? _____
"Clogged" ears/ waxy discharge? _____ Nasal Congestion, runny or bloody discharge? _____
Hoarseness or change in vocal tone? _____ Difficulty swallowing or eating/drinking? _____

HEART AND LUNGS

Chest pain (without or without exercising)? _____
Pain, dizziness or lightheadedness from any of the following:
Lying Down to Sitting? _____ Sitting to Standing? _____ Standing to Sitting? _____
Asthma, COPD, Bronchitis, Emphysema, or other breathing difficulties? _____
Pneumonia? _____

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

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

BLOOD
- Anemia? _____
- Clots or DVT (Deep Vein Thrombosis)? _____
- Lymphoma, Leukemia, Multiple Myeloma or other blood/lymphatic disorders? _____

ENDOCRINE/GLANDULAR
- Hypo (Hashimoto's) or Hyper (Graves) thyroid disorders? _____
- Cushing's (elevated Cortisol levels)? _____
- Pituitary disorders? _____
- Addison's (Primary Adrenal Insufficiency)? _____

NEURAL (NERVOUS) SYSTEM
- Epilepsy or Seizures? _____
- Peripheral Neuropathy? _____
- Bell's Palsy or Trigeminal Neuralgia? _____
- Vertigo? _____
- Sleep Apnea? _____
- Fibromyalgia? _____

STOMACH AND INTESTINES
- Nausea, heartburn, constipation, and/or diarrhea? _____
- Abdominal pain? _____
- Irritable Bowel Syndrome (IBS) or Inflammatory Bowel Disease (Crohn's)? _____
- GERD? _____
- Bloody/Black stools or ulcers? _____
- Urine darkness, lightness or discoloration? _____

KIDNEY/URETER/BLADDER (KUB)
- Frequent/infrequent or painful bowel movements or urination? _____
- Bladder infections? _____
- Excessive bloating/gas? _____
- Dehydration? _____

SKIN
- Jaundice? _____
- Moles? _____
- Liver spots, hives, other redness/rashes, eczema, nodules, or bumps? _____
- Color changes in your extremities (blue, pale, etc.)? _____
- Melanoma? _____
- Shingles? _____

PSYCHIATRIC
- Sleep difficulties? _____
- Clinical or situational depression? _____
- ADD/ADHD? _____
- Unusual crying jags? _____
- Unusual appetite or cravings? _____

FEMALE ONLY

Age of first menses _____ Have you ever been diagnoses with PMS? _____
Are you currently pregnant? _____ Are you < 10 days of your most recent menstrual cycle? _____
Are you menopausal or pre-menopausal? _____ I've had _____ Pregnancies I've had _____ Miscarriages _____

I 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.

SIGNATURE: **DATE:**