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

Name: **Nickname or preferred:** **Date:**

Registration

I am a ☐ guardian ☐ power of attorney ☐ N/A (not applicable)

- **Address/City-State-Zip:** _____
  Phone:_____ **Cell Phone:** _____
  Preferred email: _____
  SS# or Legal ID: _____ **Birthday:** _____ **Age:** ____
- **Marital Status (circle)**:
  ☐ **S**ingle ☐ **P**artner ☐ **M**arried ☐ **SO** ☐ **S**eparated ☐ **D**ivorced ☐ **W**idow(er)
- **My preferred contacts are:**
  ☐ **H**ome ☐ **W**ork ☐ **C**ell/**M**obile ☐ **e**Mail ☐ **S**pouse ☐ **M**ail ☐ **All**
- **Work information**
  Occupation/Position: _____ ☐ FT ☐ PT ☐ Disabled ☐ Retired ☐ Unemployed
  Employer: _____
  Work Address/City State Zip: _____
  Work Phone: _____
- **Family:** ☐ N/A
  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 ☐ X Age: ____ **Name**: _____ ☐ M ☐ F ☐ X Age: ____
  Name: _____ ☐ M ☐ F ☐ X Age: ____ **Name**: _____ ☐ M ☐ F ☐ X Age: ____

  If spouse is the primary insured, please complete **Spouse DOB**: ____/____/_____
  Spouse Employer: _____
  Work Address/City State Zip: _____
  Work Phone: _____
- **Emergency Contact**:
  Name: ☐ Mr. _____ ☐ Mrs. _____ ☐ Ms. _____ ☐ Dr. _____
  Phone: _____ **Relationship**: _____

Financial responsibility **BRING YOUR ID AND INSURANCE WITH YOU TO THE VISIT**

☐Self-Cash/Check/CC ☐Employer ☐Lien ☐Power of Attorney ☐Insurance
(all payments are due at the time of service unless other arrangements have been made in advance)

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.

(sign) _____ ***(date)*** _____

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Name: **Nickname or preferred:** **Date:**

Please provide the details of your injury:

- **Date of Injury (DOI):** _____ **Time:** _____
- **Please indicate the type of incident you were involved in (circle one):**
  ☐ Hit a ☐ Hit by a ☐ Slip and fall ☐ Fell ☐ Other _____
  ☐ Motor Vehicle Accident ☐ Bus ☐ Train ☐ Motorcycle ☐ Other _____
  ☐ In Office ☐ Driving ☐ Lifting ☐ Bending
- Please explain **exactly how the injury occurred:**
  I was the: ☐ Driver ☐ Front ☐ Rear ☐ Passenger- ☐ Right ☐ Left ☐ Center ☐ not in car
  And was ☐ **sitting** ☐ **facing** ☐ **turning** ☐ Left ☐ Right ☐ Up ☐ Down ☐ Backwards
  Looking ☐ Left ☐ Right ☐ Up ☐ Down ☐ Forward ☐ at rearview mirror ☐ at side view mirror
  The direction of impact was? ☐ Hit from rear ☐ Hit from side ☐ Hit from front ☐ Combination
  The direction of impact to? ☐ Hit from rear ☐ Hit from side ☐ Hit from front ☐ Combination
  Was a **safety belt worn**? ☐ Yes ☐ No ☐ Unsure Did the **vehicle roll over**? ☐ Yes ☐ No ☐ Unsure
  Were you **completely surprised on impact**? ☐ Yes ☐ No ☐ Unsure / Unconscious for _____
- Was a **police report filed**? ☐ Yes ☐ No ☐ Unsure
  - (Report number and state if applicable) _____
    Please bring or obtain a copy of the police report to your visit
- **Were other people involved**? ☐ Yes ☐ No ☐ Unsure
  If others involved, please list names and involvement _____
- **What was the speed of your vehicle? What was the speed of the other vehicle?**
- **What providers have you seen since the accident?**
- **Where did you go** after the injury (please circle)?
  ☐ Sent ☐ Drove to ☐ Drove home myself ☐ Driven home by _____
  ☐ Walked ☐ Went to _____
  Were any **tests** performed or recommended for follow up?
  ☐ Exam ☐ X-ray ☐ MRI ☐ CT scan ☐ PET scan ☐ Other _____ ☐ None
- Were **medications prescribed**? ☐Yes ☐No Did you follow recommendations? ☐Yes ☐No
- **As a result of the injury**, the following problems (either new OR worse than before the accident):

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

Please provide (below) additional information regarding the injuries and/or symptoms sustained as a result of this injury:

_____

_____

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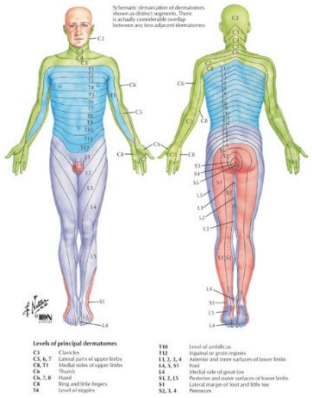
Please draw the actual incident by showing you as "1" and others as "2", "3", etc. (Diagrams are examples, you may draw on or around them):

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.)



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			

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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? _____

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

What does your typical day (as an example) consist of regarding meals, work, recreational, and what (if any) is being impeded by pain or disease?

_____

_____

MEDICATIONS AND SURGICAL HISTORY

Please include all medications, supplements/vitamins, OTC and Surgical History:
(a separate form is available if needed)

_____

_____

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

Please check YES Or NO and if YES please provide dates/years, where, who diagnosed it, etc.

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)? _____

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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? _____

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 _____ diagnosed with PMS? _____
Are you: currently pregnant? _____
< 10 days of your most recent menstrual cycle? _____
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** _____

Office Use Only: **Patient accepted for care? Y**