# 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: Personal Injury

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

- **Date of Injury (DOI):** ____/_____/_____ **Time:** ___:_____ AM/PM
- **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 your 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 draw as best as possible demonstrating you as "1" and others as "2", "3", etc.**

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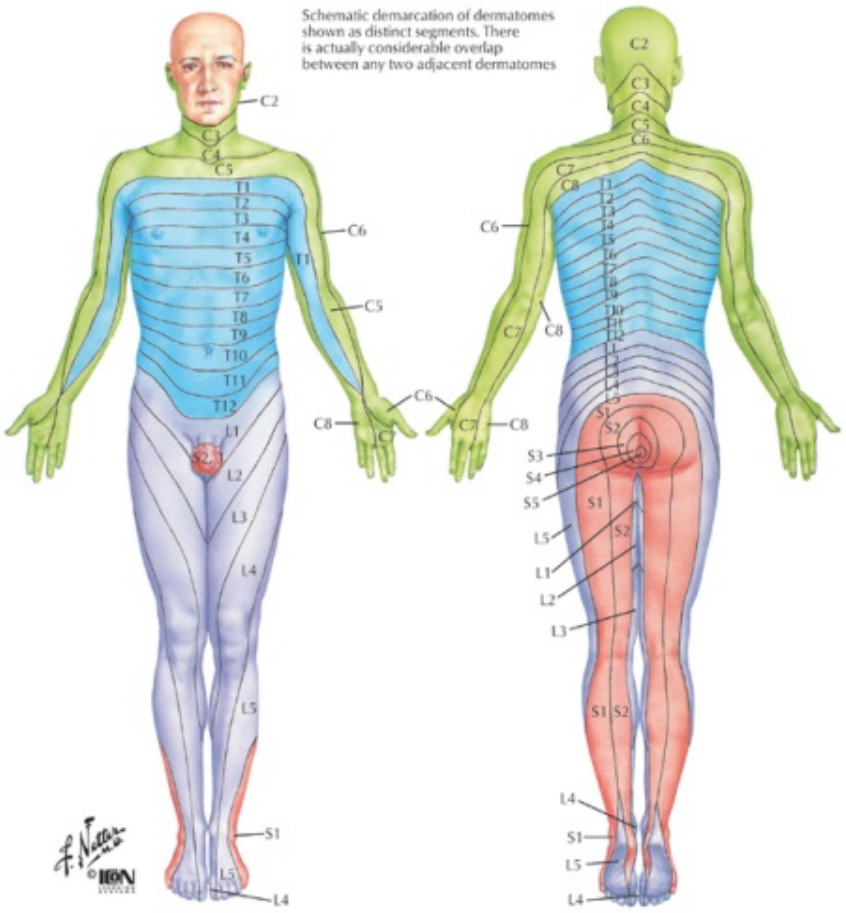
**Please draw with an X all areas affected or you would like to discuss with the doctor, and please be AS DESCRIPTIVE AS POSSIBLE (sharp, dull, achy, 'like a knife', etc.)**




**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 |

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