Harbour Healthcare, Inc.

719 High Street, Suite 118
Portsmouth, VA 23704
(PHONE) 866.601.4443 (FACSIMILE) 866.596.6056
www.myharbourhealthcare.com

(double click here on header and complete name/date)

Name: **Preferred/Nickname:** **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)**:
  ☐ Single ☐ **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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Chief Concerns

Issue 1

- LOCATION (where in the body): _____
- When did this issue occur? _____/_____/_____ or approximately _____
- 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 you had any numbing or tingling in this area? ☐ Yes ☐ **No**
  - For how long? How long does it last? _____
- What **type(s) of care** have you received for this issue?
  - Has anything made it better? _____
  - Has anything made it worse? _____
  - Medical/Chiropractic/PT/Other: _____
  - What type of tests have been performed and when? _____

Issue 2

- LOCATION (where in the body): _____
- When did this issue occur? _____/_____/_____ or approximately _____
- How did this happen? _____
- How would you characterize this problem? Please describe in terms of
  - QUALITY: _____
  - INTENSITY: _____ (0-10 scale with zero= no symptom and 10= a 'worst ever)
  - Have you had any numbing or tingling in this area? ☐ Yes ☐ **No**
  - For how long? How long does it last? _____
- What **type(s) of care** have you received for this issue?
  - Has anything made it better? _____
  - Has anything made it worse? _____
  - Medical/Chiropractic/PT/Other: _____
  - What type of tests have been performed and when? _____

If more than two issues, complete here in similar format:

_____

Name / contact number of PCP _____

Name / contact number of Specialist(s) _____

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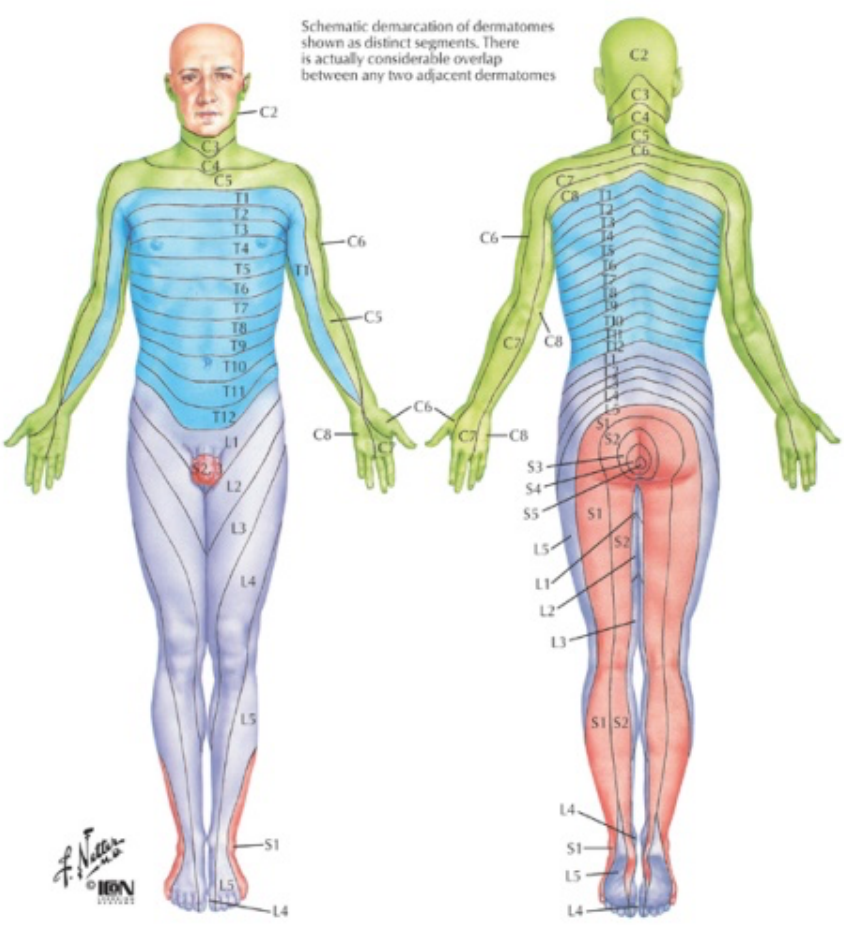
Name: **Preferred/Nickname:** **Date:** / /

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.)



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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Family History

Key:

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

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

Has anyone in your family history been diagnosed with (if yes please explain):

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

Additional Notes or Comments: _____

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Comprehensive Review Of Systems

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

GENERAL:

Do you or have you ever had	Yes	No	Details (if applicable)
Any weight loss or gain? (< > 5 lbs in one week)?	☐	☐	
Feelings of fatigue, weakness or 'drained'?	☐	☐	
Are you susceptible to fevers?	☐	☐	
Night sweats?	☐	☐	
Sports injuries?	☐	☐	
Use of a cane or walker?	☐	☐	
Concussions?	☐	☐	
Osteoarthritis?	☐	☐	
Anxiety or Panic Attacks?	☐	☐	
Cancer?	☐	☐	
Diabetes?	☐	☐	
Heart attacks?	☐	☐	
Stroke?	☐	☐	
Autoimmune disorders?	☐	☐	
Disc herniations or bulge?	☐	☐	
Broken Bones?	☐	☐	
Surgeries (minor, major, cosmetic)?	☐	☐	
Vehicular accidents (including minor injuries)?	☐	☐	
Smoker (including vaping, cigars, pipe, etc.)?	☐	☐	
Drink alcohol?	☐	☐	
Allergies?	☐	☐	
Other?	☐	☐	

MUSCULOSKELETAL:

Do you or have you ever had	Yes	No	Details (if applicable)
Back pain?	☐	☐	
Neck pain?	☐	☐	
Mid-back pain?	☐	☐	
Muscle weakness?	☐	☐	
Pain or stiffness: upon wakening?	☐	☐	
Pain or stiffness: during any physical activity?	☐	☐	
Pain or stiffness: after or during driving?	☐	☐	
Pain or stiffness: after working at a computer?	☐	☐	
Pain or stiffness: in your extremities?	☐	☐	
Pain or stiffness: any position?	☐	☐	
Joint pain or swelling?	☐	☐	

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

Pinpoint deep pain in or near a bone?	☐	☐	
Tears (rotator cuff, ACL, etc.)?	☐	☐	
TMJ or jaw pain?	☐	☐	
Other?	☐	☐	

EYES/EARS/NOSE/THROAT:

Do you or have you ever had	**Yes**	**No**	**Details (if applicable)**
Ringing in your ears?	☐	☐	
Sudden or long-term loss of hearing?	☐	☐	
Pain or dryness in, around or behind eyes?	☐	☐	
Loss of or blurry vision?	☐	☐	
Sore throats?	☐	☐	
Hoarseness or change in your vocal tone?	☐	☐	
Difficulty swallowing?	☐	☐	
Nasal congestion?	☐	☐	
Runny noses sudden or more than a few days?	☐	☐	
Frequent or extremely robust sneezing?	☐	☐	
Other?	☐	☐	

HEART AND LUNGS:

Do you or have you ever had	**Yes**	**No**	**Details (if applicable)**
Chest pain?	☐	☐	
Palpitations/flutters with/without exercising?	☐	☐	
Shortness of breath?	☐	☐	
Fainting?	☐	☐	
Dizziness/lightheaded from *sitting to standing*?	☐	☐	
Dizziness/lightheaded from *lying down to sitting*?	☐	☐	
Persistent coughs or wheezing?	☐	☐	
Irregular heartbeats?	☐	☐	
Heart failure?	☐	☐	
Swollen legs, feet or other joints?	☐	☐	
COPD (Chronic Pulmonary Lung Disease)?	☐	☐	
Bronchitis?	☐	☐	
Emphysema?	☐	☐	
Asthma?	☐	☐	
Pneumonia?	☐	☐	
Other?	☐	☐	

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NERVOUS SYSTEM:

Do you or have you ever had	Yes	No	Details (if applicable)
Headaches?	☐	☐	
Numbness or tingling?	☐	☐	
Dizziness, disorientation or fainting?	☐	☐	
Trigeminal Neuralgia?	☐	☐	
Epilepsy/Seizures?	☐	☐	
Peripheral Neuropathy?	☐	☐	
Bell's Palsy?	☐	☐	
Asperger's?	☐	☐	
Subdural Hematoma?	☐	☐	
Vertigo?	☐	☐	
Sleep apnea? Snoring?	☐	☐	
Other?	☐	☐	

STOMACH AND INTESTINES:

Do you or have you ever had	Yes	No	Details (if applicable)
Nausea?	☐	☐	
Heartburn?	☐	☐	
Stomach pain?	☐	☐	
Vomiting?	☐	☐	
Yellow (jaundice)?	☐	☐	
Constipation?	☐	☐	
Diarrhea?	☐	☐	
Ulcers?	☐	☐	
Bloody stools?	☐	☐	
Black stools?	☐	☐	
Intestinal parasites?	☐	☐	
Fibromyalgia?	☐	☐	
IBS (Irritable Bowel Syndrome)?	☐	☐	
IBD (Inflammatory a/k/a Crohn's)?	☐	☐	
GERD (GastroEsophageal Reflux Disease)?	☐	☐	
Gluten Sensitivity?	☐	☐	
Hemorrhoids?	☐	☐	
Other?	☐	☐	

SKIN:

Do you or have you ever had	Yes	No	Details (if applicable)
Redness or rashes?	☐	☐	
Liver Spots?	☐	☐	

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Nodules or Bumps?	☐	☐	
Changes with or rapid hair loss?	☐	☐	
Color changes (blue, pale, etc.) in extremities?	☐	☐	
Moles?	☐	☐	
Melanoma?	☐	☐	
Rosacea?	☐	☐	
Lupus?	☐	☐	
Eczema?	☐	☐	
Hives?	☐	☐	
Fungal nail infections?	☐	☐	
Cellulitis?	☐	☐	
Shingles?	☐	☐	
Other?	☐	☐	

BLOOD:

Do you or have you ever had	Yes	No	Details (if applicable)
Anemia?	☐	☐	
Clots?	☐	☐	
DVT (Deep Vein Thrombosis)?	☐	☐	
Lymphoma?	☐	☐	
Leukemia?	☐	☐	
Color changes (blue, pale, etc.) in extremities?	☐	☐	
Multiple Myeloma?	☐	☐	
Other?	☐	☐	

KIDNEY/URETER/BLADDER:

Do you or have you ever had	Yes	No	Details (if applicable)
Frequent or painful urination?	☐	☐	
Blood in urine?	☐	☐	
Persistent back pain in your flanks?	☐	☐	
Dehydration?	☐	☐	
Bladder infections?	☐	☐	
Very dark or overly light urine?	☐	☐	
Abdominal pain? Excessive bloating or gas?	☐	☐	
Other?	☐	☐	

PSYCHIATRIC:

Do you or have you ever had	Yes	No	Details (if applicable)
Excessive worries?	☐	☐	
Difficulty falling asleep or staying asleep?	☐	☐	
Unusual appetites or cravings?	☐	☐	

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Crying jags without provocation?	☐	☐	
Situational stress?	☐	☐	
Poor concentration?	☐	☐	
ADD/ADHD?	☐	☐	
Hallucinations?	☐	☐	
Mood swings?	☐	☐	
Depression (situational or long term)?	☐	☐	

FEMALE ONLY

	Yes	No	Details (if applicable)
Age of first period?	☐	☐	(approximate month/year) _____/_____
Have you ever or do you have PMS?	☐	☐	
Are you currently pregnant?	☐	☐	If yes, how many weeks/months?
Your last menstrual cycle began?			MM/~DD/YY _____
Within the last 10 days?	☐	☐	
Are you menopausal?	☐	☐	If yes, began~? _____
Pregnancies?	☐	☐	_____
Miscarriages?	☐	☐	_____

I, _____***,***

PRINT

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*