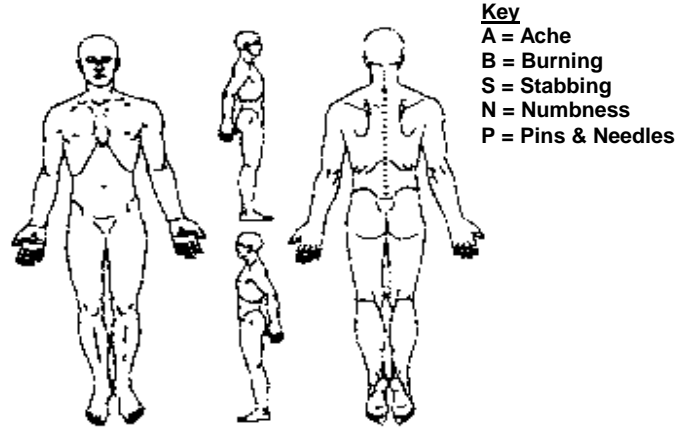


Please Fill In Below

If you have had the following, or if you suffer from the following, Please Check

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache		
Migraines		
Neck pain		
Shoulder pain		
Arm/hand pain		
Mid back pain		
Low back pain		
Hip pain		
Leg/foot pain		
Disc problems		
Arthritis		
Other joint pain		
Numbness		
Joint Swelling		
Dizziness		
Nausea		
Weakness		
Fatigue		
Nervousness		
Insomnia		
Heart Problems		
Frequent Colds		
Nose Bleeds		
Ringing in Ears		
Earaches		
Hearing Loss		
Cough		
Chest Pains		
Female Problems		
Allergies		
Asthma		
Cancer Symptoms		
Osteoporosis		
Diabetes		
Hypoglycemia		
Digestive Problems		
Urinary Problems		
Skin Conditions		
Other _____		

Use the letters listed below to indicate the *type* and *location* of your pain and sensations...



Below, please fill in any other health information you feel we might need for your care.

Thank you for being complete and thorough.

Authorization to release medical information and Financial Agreement

I hereby authorize this office to release any information requested by my insurance company to document my claim for benefits. I understand that I am personally responsible for full payment of all charges for my treatment. Services are payable at the time rendered.

Signature: _____
Date: ____/____/____

If you are planning on utilizing insurance please present your insurance card to the front desk. Please include birth date and SSN of the person responsible for your payment. It is our pleasure and privilege to serve you.



**Forcey Chiropractic Center
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