



562 KINGWOOD DRIVE

KINGWOOD, TX 77339

281-354-8330

Application Form

WELCOME TO OUR OFFICE. We specialize in helping people achieve their highest level of health through our Neurological, Brain-Based, and Metabolic corrective programs. Our approach is unique and advanced from other rehabilitative programs; therefore, we have strict requirements in accepting new patients. This approach allows our patients to achieve far superior results compared to most other systems.

In order to be seen, you agree to:

1. Fill out the following forms as thoroughly as possible so that we can determine whether we can accept your case. **These forms must be completed and brought with you to your scheduled appointment.**
2. Watch the VIDEO explaining "What Makes Us Unique."
3. Wear loose fitting clothing (preferably without metal) so Dr. Clark can access from your elbows down and your knees down as he is going to be doing a complete structural and neurological examination and may need to take x-rays.
4. Please bring copies of all lab studies and diagnostic test results that you have had within the last year along with this packet.

I agree to the above terms and understand that should I NOT meet these terms I will be asked to reschedule my appointment.

Patient History

Check **ALL** that apply to you, currently or in the past:

CERVICAL SPINE (NECK):

Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands, and head, affecting these parts of your body. Do you experience any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pain into your shoulders/arms/hands ___L ___R | |
| <input type="checkbox"/> Vertigo/Dizziness | <input type="checkbox"/> Numbness/tingling in arms/hands ___L ___R | |
| <input type="checkbox"/> Visual disturbances | | |
| <input type="checkbox"/> Sinusitis/sinus infections | <input type="checkbox"/> Low Energy/Fatigue | <input type="checkbox"/> Coldness in hands |
| <input type="checkbox"/> Weakness in grip | <input type="checkbox"/> Thyroid conditions | <input type="checkbox"/> TMJ/Pain/Clicking |
| <input type="checkbox"/> Migraines/Headaches | <input type="checkbox"/> Recurrent colds/Flu | <input type="checkbox"/> Hearing problems |

THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Asthma/Wheezing |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Shortness Of Breath | |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Pain On Deep Inhalation/Exhalation | |
| <input type="checkbox"/> Heart Attacks/Angina | <input type="checkbox"/> Recurrent Lung Infections/Bronchitis | |

THORACIC SPINE (MID BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the mid back will weaken the nerves into your ribs/chest and upper digestive tract and affect the following parts of your body. Do you experience do any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Pain Into Your Ribs/Chest | <input type="checkbox"/> Ulcers/Gastritis |
| <input type="checkbox"/> Indigestion/Heartburn | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Tired/Irritable after eating |

LUMBAR SPINE (LOW BACK):

Postural distortions from subluxations in the low back (resulting from Forward Head Syndrome) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Constipation / Diarrhea |
| <input type="checkbox"/> Numbness/tingling in your legs/feet ___L ___R | <input type="checkbox"/> Recurrent bladder infections |
| <input type="checkbox"/> Coldness in your legs/feet ___L ___R | <input type="checkbox"/> Frequent/difficulty urinating |
| <input type="checkbox"/> Muscle cramps in your legs/feet ___L ___R | <input type="checkbox"/> Menstrual irregularities/cramping (females) |
| <input type="checkbox"/> Pain into your hips/legs/feet ___L ___R | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Weakness/injuries in your hips/knees/ankles | |

Main Complaint: _____

How did it start? _____

Grade Intensity / Severity (0 = no pain; 10 = extremely severe pain) 0 1 2 3 4 5 6 7 8 9 10

What have you tried to do to get rid of this problem that **DID NOT** work? _____

Have you become discouraged about handling this problem? _____

How does this problem interfere with areas of your life? _____

What do you do that makes this problem worse? _____

What gives you some temporary relief? _____

What is the pattern of this problem? Constant ___ Intermittent ___ Occasional ___ Cyclic ___

List **ALL** Previous hospitalizations, surgeries, accidents, fractures, and illnesses:

1. Type _____ When _____ Hospitalized? Yes___ No___
2. Type _____ When _____ Hospitalized? Yes___ No___
3. Type _____ When _____ Hospitalized? Yes___ No___
4. Type _____ When _____ Hospitalized? Yes___ No___
5. Type _____ When _____ Hospitalized? Yes___ No___

Check **ALL** that apply to you.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> High Blood Sugar | <input type="checkbox"/> Lyme's Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Learning Difficulties | <input type="checkbox"/> IBS | <input type="checkbox"/> Gout | <input type="checkbox"/> Raynaud's Syndrome |
| <input type="checkbox"/> Memory Loss | | <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Unable to Focus | | | |
| <input type="checkbox"/> Parkinson's Disease | | | |

Please check all of the following conditions your family have or currently suffer from:

Alzheimer's Cancer Diabetes Heart Disease Parkinson's MS Stroke Autoimmune conditions (i.e. Lupus, RA, Psoriasis, MS, Hashimoto's, etc.)

Could your problem have been caused by an injury at work? _____

If yes, please give us the details: _____

Do you have any children? _____

Do they have any health problems that you are aware of? _____

Have you experienced any unexplained or rapid weight changes in the last six months? Yes___ No___

Our Fee Structure

Please note our fees for your initial visit:

Consultation	COMPLIMENTARY
Complete Neurologic Examination <i>(*X-rays will be included if deemed necessary)</i>	\$145.00
TOTAL=	\$ 145.00

Exceptions:

- If you have been involved in a motor vehicle accident, our fee structure may differ due to the complexity of your needs in such cases.
- If you are coming in from an ad or a Facebook post our fee structure may differ from above.

I fully understand the above fees and give my consent for the doctor to perform a complete neurologic exam. I also give my consent to have the doctor take any x-rays he/she deems appropriate to better understand my problem and monitor my progress.

Consent for Radiology

I, _____, give the doctors of this Chiropractic and Wellness Center my consent to take all x-rays needed to better understand my condition. I have been fully informed of the possible risks and safety standards of this office. I also give my consent for films of my child (children) for the same reasons, if applicable.

[For women: To my best knowledge I am not pregnant and know of no contraindications for x-rays at this time.]

Patient Signature: _____ **Date:** _____
(Signature of Parent/Guardian required if patient under age 18)

Treatment Consent Form

**Before receiving consultation or treatment in our office,
Please review the principles outlined below:**

1. I understand that Dr. Clark's goal is to provide me with adjunctive and supportive care for my health condition. Clark Chiropractic & Wellness does not claim to treat or cure any disease or medical diagnosis.
2. I understand that this office offers some services not covered by insurance. These services are considered experimental and may or may not be billed to my insurance. Dr. Clark will review all services that are considered covered services and those that are not. Nutritional support may also be offered for my case. Nutritional supplements are not FDA regulated and have not been proven to cure or treat any disease or illness.
3. I understand that Clark Chiropractic & Wellness' services are not a replacement for my medical treatment. Clark Chiropractic & Wellness chooses to work alongside my medical provider, as this serves me in the most effective manner.
4. Dr. Clark will never give advice on the use of my medications. Medications must be managed by my medical doctor. I must work with a medical doctor for the management of any medications I take now or in the future.
5. I completely understand that there are no guarantees of help, correction, relief, or cure, whether written, spoken, or implied. I understand that this clinic does NOT treat any disease or any medical diagnosis.
6. I am making a sane and conscious decision to seek advice as per the above understood terms for either myself and/or my dependents. In doing so, I agree to the above terms and acknowledge this with my signature.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____