562 KINGWOOD DR

KINGWOOD, TX 77339

281-354-8330

Patient Update

Personal History

Your Name: ____
First Middle Last

Address: ____
____

Telephone: Home: ______________________, Cell: ______________________

Birth Date: ______________ Email: ______________________

Marital Status: ______________ Spouse's Name: ______________________

Occupation: ______________ Employer: ______________________

Insurance Card: ______________ Date of last visit to our Center: ______________

Health History

1. To the best of your recollection, for what reason had you decided to leave our office initially?
____

2. Please describe your health status since your last visit to our clinic including, visits to other doctors, hospital stays, medications and/or supplements you are/have taken, motor vehicle accidents and/or any work related injuries: ____
____
____

3. Have you had any major lifestyle changes since your last visit (e.g. marriage, children, and employment)?
____
____
____

4. What is your reason for today's visit?____

5. Is there anything else you would like us to know?

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: ______________

Our Fee Structure

Today's visit may include any of the following:

	Total Fee	Ins.(if available)	Patient Fee
Examination	$45		
X-Rays	$50-$100		
Total	$95-$145		

Signature: ______________________________ ***Date:*** ____________________________

Consent for Radiology

I, ______________________________, give the doctors of Clark Chiropractic & Wellness my consent to take any and 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 Ladies only:
To the best of my knowledge I am not pregnant and know of no contraindications for x-rays at this time.

Patient Signature: ___________________________ Date: ____________________

Thank You!