562 KINGWOOD DRIVE

KINGWOOD, TX 77339

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.

2. 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.

3. Please bring copies of all lab studies and diagnostic test results that you have had within the last year along with this packet.

Patient Introduction

Fill out as much information as possible, but the highlighted is the most necessary.

Personal History:

Name: ____
First Middle Last

Address: Street:____
City:________________ State:______________ Zip Code:____________

Telephone: Home:______________________ Cell: ___________________

May we send text messages regarding your appointment times and special events? Y / N

Email Address (office use only): ____

Birth Date: ____/____/_______

Marital Status: ____________ Spouse's Name: __________________________

Occupation: ____

Employer: ____

Circle how you heard about our office?

Google Search YouTube Facebook Instagram

Other ___________________________ Person ___________________________

List Chiropractors you have seen before:
1. Name:________________________ When Visited:______________________
2. Name:________________________ When Visited:______________________

List Medical Doctors consulted within the past year:
1. Name: ________________________ Reason for visit?____________________
2. Name: ________________________ Reason for visit?__________________

Patient History

Name: ________________________________ Date:________________

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

CERVICAL SPINE (NECK):
Do you experience any of the following?

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

THORACIC SPINE (UPPER BACK):
Do you experience any of the following?

- ☐ Heart Palpitations
- ☐ Heart Murmurs
- ☐ Tachycardia
- ☐ Heart Attacks/Angina
- ☐ Upper Back Pain
- ☐ Shortness Of Breath
- ☐ Pain On Deep Inhalation/Exhalation
- ☐ Recurrent Lung Infections/Bronchitis
- ☐ Asthma/Wheezing

THORACIC SPINE (MID BACK):
Do you experience do any of the following?

- ☐ Mid Back Pain
- ☐ Pain Into Your Ribs/Chest
- ☐ Indigestion/Heartburn
- ☐ Reflux
- ☐ Nausea
- ☐ Ulcers/Gastritis
- ☐ Hypoglycemia
- ☐ Tired/Irritable after eating

LUMBAR SPINE (LOW BACK):
. Do you experience any of the following?

- ☐ Low back pain
- ☐ Numbness/tingling in your legs/feet ___L ___R
- ☐ Coldness in your legs/feet ___L ___R
- ☐ Muscle cramps in your legs/feet ___L ___R
- ☐ Pain into your hips/legs/feet ___L ____R
- ☐ Weakness/injuries in your hips/knees/ankles
- ☐ Constipation / Diarrhea
- ☐ Recurrent bladder infections
- ☐ Frequent/difficulty urinating
- ☐ Menstrual irregularities/cramping (females)
- ☐ Sexual dysfunction

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

Our Fee Structure

Consultation	**COMPLIMENTARY**
Complete Neurologic Examination ***(*X-rays will be included if deemed necessary usually $145)***	**$95.00**
TOTAL=	**$ 95.00**

- 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.

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: ______________________

Witness 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.
7. I give permission to **Clark Chiropractic and Wellness** to use my image, voice, or likeness in photos, videos, or other media for promotional or educational purposes.
   I understand that my participation is voluntary and that I will not receive compensation.

Patient Signature: ______________________________________ Date: ___________________________

Witness Signature: ______________________________________ Date: _________________________

(Signature of Parent/Guardian required if patient under age 18)