



562 KINGWOOD DR  
KINGWOOD, TX 77339

281-354-8330

## Child 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 on your scheduled appointment.**
2. Watch the VIDEO explaining “What Makes Us Unique.”
3. Wear or bring a t-shirt and shorts (preferably without metal) as the doctor will be performing a full neurological exam and may 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.**

Signature \_\_\_\_\_

Date \_\_\_\_\_



## New Patient Child Application

Patient Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_

Sex: M F Age \_\_\_\_\_ SS# \_\_\_\_\_

### Parent/Guardian Information

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_

Email Address (office use only)

\_\_\_\_\_

Sex: M F Age \_\_\_\_\_ Marital Status: M D W S Spouse \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

How did you hear about our clinic?

\_\_\_\_\_

### Child's History

Primary health challenge: \_\_\_\_\_

Severity (0-10) \_\_\_\_\_

Secondary challenge (if any) \_\_\_\_\_

Severity (0-10) \_\_\_\_\_

Medications: \_\_\_\_\_

Supplements: \_\_\_\_\_

**Please rate the following 0-10 (0 = not at all 10 = extremely severe)**

- |                                      |  |   |   |
|--------------------------------------|--|---|---|
| <input type="checkbox"/> Anxiety     | <input type="checkbox"/> Learning Disorder | <input type="checkbox"/> Poor Concentration             | <input type="checkbox"/> Insomnia (staying<br>asleep)   |
| <input type="checkbox"/> Depression  | <input type="checkbox"/> Unable to Focus   | <input type="checkbox"/> Obsessive Behavior             | <input type="checkbox"/> Difficulty using<br>body parts |
| <input type="checkbox"/> ADD / ADHD  | <input type="checkbox"/> Memory Problems   | <input type="checkbox"/> Insomnia (getting to<br>sleep) |   |
| <input type="checkbox"/> Fatigue     | <input type="checkbox"/> Headaches         |   |   |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Ringing in Ears   |   |   |
| <input type="checkbox"/> Anger       |  |   |   |

**Do you have family members with any of the above difficulties?** (Yes, No) If so, who? \_\_\_\_\_

**Have you had a seizure at any time?** (Yes, No) If so, when? \_\_\_\_\_

**Are your eyes sensitive to light?** (Yes, No)

**Have you had any head injuries** (diagnosed or undiagnosed?) (Yes, No)

If yes, please explain \_\_\_\_\_

**How many auto accidents have you been in?** (fender benders count) \_\_\_\_\_

**Please list any other accidents or falls** \_\_\_\_\_

**Please list any surgeries** \_\_\_\_\_

**What specific behaviors do you hope to see improve or eliminated?** \_\_\_\_\_

1. Please identify family history in any of the following conditions: (if so, who?)

a. Psychiatric conditions (yes, no) \_\_\_\_\_

b. Autism spectrum conditions (yes, no) \_\_\_\_\_

c. Autoimmune conditions (yes, no) \_\_\_\_\_

d. Genetic conditions (yes, no) \_\_\_\_\_

2. How was the mother's pre-pregnant health? \_\_\_\_\_

a. Miscarriages? \_\_\_\_\_

b. Fertility Treatments? \_\_\_\_\_

c. Health of other children? \_\_\_\_\_

d. Physical Abuse? \_\_\_\_\_

e. Major Illnesses? \_\_\_\_\_

f. Known Autoimmune Conditions (Rheumatoid Arthritis, Lupus, MS, Hashimoto's)?

\_\_\_\_\_

g. Toxin Exposure to:

Molds  Yes  No

Pesticides  Yes  No

Dental Work \_\_\_\_ Yes \_\_\_\_ No

h. Known Infections \_\_\_\_ Yeast \_\_\_\_ Bacterial \_\_\_\_ Parasite

i. Did mother (while pregnant)

Drink alcohol \_\_\_\_ Yes \_\_\_\_ No

Drink coffee \_\_\_\_ Yes \_\_\_\_ No

Smoke tobacco \_\_\_\_ Yes \_\_\_\_ No

Take Progesterone \_\_\_\_ Yes \_\_\_\_ No

Take prenatal vitamins \_\_\_\_ Yes \_\_\_\_ No

Take antibiotics \_\_\_\_ Yes \_\_\_\_ No

Take other drugs \_\_\_\_ Yes \_\_\_\_ No

Excessive vomiting, nausea (more than 3 weeks) \_\_\_\_ Yes \_\_\_\_ No

Have a viral infection \_\_\_\_ Yes \_\_\_\_ No

Have bleeding \_\_\_\_ Yes \_\_\_\_ No

Group B strep infection \_\_\_\_ Yes \_\_\_\_ No

### 3. Birth

a. During the child's delivery, were forceps or suction used? \_\_\_\_\_

b. Was birth by C-Section? \_\_\_\_\_

c. Was labor induced? \_\_\_\_\_

d. Did Mother have an epidural? \_\_\_\_\_

e. What was child's APGAR score? \_\_\_\_\_

### 4. Infancy

a. Was child exposed to mold? \_\_\_\_\_

b. Was house treated with pesticides? \_\_\_\_\_

c. Was the house painted, either inside or outside? \_\_\_\_\_

### 5. Motor Development

At what age did your child do the following?

Sit up \_\_\_\_\_ Crawl \_\_\_\_\_ Pull to Stand \_\_\_\_\_ Walk Alone \_\_\_\_\_

Potty-trained \_\_\_\_\_ Dry at Night \_\_\_\_\_ First Words ("mama", "dada" etc.) \_\_\_\_\_

Speak clearly \_\_\_\_\_ Lost language (if applicable) \_\_\_\_\_

Lost eye contact (if applicable) \_\_\_\_\_

Did your child display any "cute" behaviors when learning to crawl or walk? (for example, dragging on leg, or crawling on all fours with rear end up in air) \_\_\_\_\_

Was child breast-fed? \_\_\_\_\_ How long? \_\_\_\_\_

Bottle-fed? \_\_\_\_\_ Was formula Soy-based \_\_\_\_\_ Casein (Milk)-based? \_\_\_\_\_

Did baby have any reactions to the formula? If so, describe \_\_\_\_\_

At what age was cow's milk introduced? \_\_\_\_\_

At what age was rice introduced? \_\_\_\_\_ Wheat and other grains introduced at what age? \_\_\_\_\_

#### 6. Early Childhood

- a. Number of earaches in the first two years \_\_\_\_\_
- b. Number of other infections in the first two years \_\_\_\_\_
- c. Number of times you had antibiotics in the first two years of life \_\_\_\_\_
- d. Number of courses of prophylactic antibiotics in the first two years of life \_\_\_\_\_
- e. First antibiotic at? \_\_\_\_\_
- f. First illness at? \_\_\_\_\_
- g. Has your child been vaccinated? \_\_\_\_\_

If so, did they have any of the following after the vaccines? Diarrhea \_\_\_\_\_ Crying \_\_\_\_\_  
Swelling at injection site? \_\_\_\_\_ Seizure \_\_\_\_\_ Fever \_\_\_\_\_ Irritable \_\_\_\_\_

#### 7. Current Diet

- a. Does your child refuse to eat particular textures, temperatures, or certain kinds of food? (If so, describe) \_\_\_\_\_
- b. Does your child eat a lot of or crave any of the following?  
Sweets (cookies, candy, sugar) \_\_\_\_\_  
Dairy products (milk, cheese, ice cream) \_\_\_\_\_  
Breads, pasta, potatoes, chips \_\_\_\_\_  
Sweet drinks (Gatorade, Powerade, Capri Sun, Sunny-D, Soda, Fruit juices) \_\_\_\_\_  
Salty Foods \_\_\_\_\_
- c. Does your child eat only 2-4 kinds of foods daily? \_\_\_\_\_

#### 8. Gastrointestinal Issues

- a. Does your child suffer from any of the following?  
Constipation \_\_\_\_\_  
Diarrhea \_\_\_\_\_  
Bloating \_\_\_\_\_  
Dark circle under eyes \_\_\_\_\_  
Do the child's symptoms/behaviors get worse in the following weather?  
Damp \_\_\_\_\_ hot \_\_\_\_\_ misty \_\_\_\_\_ moldy \_\_\_\_\_ musty \_\_\_\_\_  
Does the child wake at night laughing or giggling \_\_\_\_\_?  
Child puts pressure on stomach (with hands or by lying over couch arms etc.) \_\_\_\_\_



## Our Fee Structure

*Please note our fees for your initial visit:*

<b>Consultation</b>	Complimentary
<b>Examination</b>	\$ 45.00
<b>Radiology</b>	Variable (up to a maximum of \$100.00)
<b>TOTAL</b>	<b>\$ 145.00</b>

Please note that 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.

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.

I have received a copy of the Notice of Privacy Practices from Clark Chiropractic.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



## Consent for Treatment of a Minor Child

I, \_\_\_\_\_, the  mother  father  legal guardian of  
\_\_\_\_\_, give Clark Chiropractic and Wellness Center the rendering of care  
including diagnostic procedures, x-rays, and all treatment.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Dr. Lewis Clark DC, CCWP, BCIM, CGP

23836 HIGHWAY 59 N KINGWOOD, TX 77339 • 281-354-8330 • [www.clarkchiropractic.net](http://www.clarkchiropractic.net)

## Treatment Consent Form

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**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 and Dr. 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: \_\_\_\_\_



# Child Neurotransmitter & Nutrition Questionnaire (CNNQ)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

\* Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

## SECTION: GENERAL

- Does your child have any food sensitivities or allergies? (please list)

\_\_\_\_\_

\_\_\_\_\_

- List your child's 4 healthiest foods eaten regularly.

\_\_\_\_\_

\_\_\_\_\_

- List your child's 4 unhealthiest foods eaten regularly.

\_\_\_\_\_

\_\_\_\_\_

- How many times a week does your child eat candy? \_\_\_\_\_

- How many times a week does your child drink soda pop? \_\_\_\_\_

- Please list the top 4 foods your child craves regularly?

\_\_\_\_\_

\_\_\_\_\_

- List the medication(s) your child is currently prescribed and over the counter.

\_\_\_\_\_

\_\_\_\_\_

- Do you find it difficult as a parent to have your child on a special diet?

\_\_\_\_\_

## SECTION: A (K52)

- Does your child eat pasta, breads, and breaded foods? 0 1 2 3
- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating wheat foods? 0 1 2 3
- Does your child eat dairy products? 0 1 2 3
- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating dairy products? 0 1 2 3

## SECTION: B (K53)

- Does your child eat fried fish? 0 1 2 3
- Does your child eat roasted nuts or seeds? 0 1 2 3
- Is your child **missing** essential fatty acid rich foods in his/her diet? (for example: avocados, flax seeds, olives) (mark "0" if present, "3" if missing) 0 1 2 3
- Does your child eat *fried* foods? 0 1 2 3

## SECTION: C (K34)

- Is your child's mental speed slow? 0 1 2 3
- Does your child have difficulty with learning or memory? 0 1 2 3
- Does your child have difficulty with balance and coordination? 0 1 2 3

## SECTION: D (K16)

- Does your child have stress? 0 1 2 3
- Does your child **not** have enough sleep and rest? (mark "3" if not enough) 0 1 2 3
- Does your child **not** have regular exercise? (mark "3" if no exercise) 0 1 2 3
- Does your child feel overly worried and scared? 0 1 2 3

## SECTION: E (K16, K51)

- Does your child have temper tantrums? 0 1 2 3
- Does your child exhibit wild behavior? 0 1 2 3
- Does your child frequently yell or scream for unnecessary reasons? 0 1 2 3

- Does your child have an **inability** to nap or sleep when physically exhausted? (mark "3" if unable) 0 1 2 3
- Is your child overly talkative? 0 1 2 3
- Does your child fidget and squirm when seated? 0 1 2 3
- Does your child run and climb excessively when it is inappropriate? 0 1 2 3
- Does your child have difficulty playing quietly or engaging in leisure activities? 0 1 2 3

## SECTION: F (K51)

- Does your child get excited easily? 0 1 2 3
- Does your child have anxiousness and panic for minor reasons? 0 1 2 3
- Does your child feel overwhelmed for minor reasons? 0 1 2 3
- Does your child find it difficult to relax when she/he is awake? 0 1 2 3
- Does your child have disorganized attention? 0 1 2 3

## SECTION: G (K50)

- Does your child seem depressed? 0 1 2 3
- Does your child have mood changes with overcast weather? 0 1 2 3
- Does your child have symptoms of inner rage? 0 1 2 3
- Does your child seem uninterested in games or hobbies? 0 1 2 3
- Does your child have difficulty falling into deep restful sleep? 0 1 2 3
- Does your child seem uninterested in friendships? 0 1 2 3
- Does your child have symptoms of unprovoked anger? 0 1 2 3
- Does your child seem uninterested in eating? 0 1 2 3

## SECTION: H (K49)

- Does your child have difficulty handling stress? 0 1 2 3
- Does your child have anger and aggression while being challenged? 0 1 2 3
- Does your child feel tired even after long sleeps? 0 1 2 3
- Does your child tend to isolate from others? 0 1 2 3
- Does your child get distracted easily? 0 1 2 3
- Does your child have constant need and desire for candy and sugar? 0 1 2 3
- Does your child have disorganized attention? 0 1 2 3

## SECTION: I (K48)

- Does your child have difficulty with visual memory? 0 1 2 3
- Does your child have difficulty remembering locations? 0 1 2 3
- Does your child have fatigue or low endurance for learning activities? 0 1 2
- Does your child have difficulty with attention or low attention span or endurance? 0 1 2 3
- Does your child have slow or difficult speech? 0 1 2 3
- Does your child have uncoordinated or slow movement? 0 1 2 3

