



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: _____

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
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!

