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_____

Clark CHIROPRACTIC & WELLNESS
Live Life Well

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)

____Anxiety
____Depression
____ADD / ADHD
____Fatigue
____Mood Swings
____Anger
____Learning Disorder
____Unable to Focus
____Memory Problems
____Headaches
____Ringing in Ears
____Poor Concentration
____Obsessive Behavior
____Insomnia (getting to sleep)
____Insomnia (staying asleep)
____Difficulty using body parts

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.) _____

Clark
CHIROPRACTIC
& WELLNESS
Live Life Well

Our Fee Structure

Please note our fees for your initial visit:

Consultation	Complimentary
Examination	$ 45.00
Radiology	Variable (up to a maximum of $100.00)
TOTAL	**$ 145.00**

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

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 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: avocadoes, 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**