****IMPORTANT****

PLEASE READ THIS PAGE CAREFULLY

In order for you to get better as fast as possible, we need the help of ALL persons significantly involved in your support system. Spouse, children and other family members all play a crucial role in your successful recovery. In short, it is extremely important that everyone is "on the same page."

Therefore, we require that all persons directly in your support system sign this affidavit. This form must be returned with your Case Review and Case History forms before Dr. Clark can examine you.

AFFIDAVIT

I (each) the undersigned individual certify that:

- I understand that Dr. Clark's methods and treatment are unique.
- I understand that Dr. Clark does not accept every person into his treatment program.

_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature

Thank you for taking the time to make sure you get the best results possible in the fastest time.

Return this with your Case History forms.

Neuro-Developmental
Case Review & Case History

To Parents...

This questionnaire is intended to give you a way of describing your child as an individual.

These questions give us vital clues that influence our thinking about treatment options.

Whatever label has been given to you, keep in mind that it is just a label. It doesn't tell us what to do.

Your answers to these questions and the results of your child's examination will tell us how to help your child as fast as possible.

Sincerely,

----> **NOTE: TYPE OUT the answers to the following questions and MAKE SURE to return them with your packet. Dr. Clark cannot see your child if any of your packet is incomplete.**

HEALTH HISTORY QUESTIONS

1. Please list parents' education, profession, sports and hobbies
2. List your **chief concerns about your child in order of your importance**
3. Provide a detailed narrative (story) of your child's health history in a timeline sequence
4. List all diagnoses given to your child in a timeline sequence and your personal opinions about the diagnosis
5. List your opinion on what you think has happened to your child's health
6. List of all healthcare providers you have consulted and their opinions and treatments about your child's case
7. List any treatments, medications, or supplements that have improved your child's health
8. List any treatments, medications, or supplements that have caused reactions or decreased your child's health
9. List in a timeline sequence and medications your child has taken
10. List any special diets you have tried and describe your child's response.
11. List in a timeline sequence any hospitalization, head injuries, medical procedures or surgeries your child has had
12. List in a timeline sequence any significant laboratory or imaging results
13. List in a timeline sequence any exposure to environmental, industrial, or toxic compounds.
14. List any history of infections (excluding common colds).
15. List ALL current medications, herbs, vitamins, supplements etc
16. Describe your family's medical history (mom, dad, grandparents, siblings)

PERSONAL OPINION QUESTIONS

Please do not answer, "I don't know" to any of these questions

1. Why do you think healthcare practitioners have failed with your child's case?
2. Do you think your child's condition can be cured, or improved?
3. What do you consider a realistic time frame to see changes in your child's health under our care?
4. What are your expectations from us?
5. Is there anyone you blame for your child's health condition?
6. What specific improvements in your child's health would you consider a successful outcome in your case?
7. Are you emotionally and spiritually able to handle further investigation and management of your child's case?
8. Is there anything else you feel you should tell us about yourself or your child's case?
9. Is there anything in what you believe about health and the body that you may think is holding back your child's health?
10. Are you willing to change what you believe about health and the body to gain more health for your child?
11. Are there any emotional experiences that can be affecting to your child's health condition?
12. Is your spouse and/or family unit supportive of dealing with your child's health condition?
13. Are your spouse and/or family unit supportive of you seeking care for your child at our office?
14. How did you feel about answering all of these questions?

Confidential Neuro-Developmental Case History

Name _____ Date of Birth _____

How does your child wish to be addressed in our office? ☐ First name ☐ Nickname_____

Parent/Guardian _____ Home Phone _____ Cell_____

Address _____City _____ Zip _____

Parent's work phone _____Parent's email_____

Child lives with ☐ both parents ☐ mother ☐ father ☐ other _____

Emergency Contact: Name _____ Relationship_____Phone_____

What are you hoping Dr. Clark tells you today?_____

_____

Describe what you hope or think Dr. Clark might be able to do for your child _____

_____

Describe what will be different/better in your life if you can finally be relieved of these problems._____

_____

What do you desire most to get from working with us?_____

What is your idea of the ideal doctor? _____

_____

Is your child: ☐ right handed ☐ left handed ☐ switches with different activities

☐ was left handed, but now is right ☐ was right handed but now is left

Vaccination History:

Please indicate if your child had a "reaction" to any of the following vaccines, and what kind of reaction:

Name of Vaccine	GI/ Bowel	Fever	Prolonged or inconsolable crying	Seizure	Irritable	Swelling at Site
Diphteria-Pertussis-Tetanus (DPT)						
Hemophilus Influenza B (HIB)						
Oral Polio Vaccine						
Polio Vaccine Injection						
Measles-Mumps-Rubella (MMR)						
Hepatitis B (HBV)						
Chicken Pox						
Flu **Shot**						

Mother's Past Pregnancies: number of Pregnancies_____ Live births _____ Miscarriages _____

Mother's Pregnancy: Place a check mark if any of the following occurred during your pregnancy.

During the pregnancy, did you:	Yes	Describe if applicable
Difficulty getting pregnant (more than 6 months)		
Infertility drugs used		
In vitro fertilization		
Drink alcohol		
Drink coffee		
Use Tobacco or Nicotine		
Take progesterone		
Take prenatal vitamins		
Take anitbiotics		
Take other medications		
Excessive vomiting, nausea (more than 3 weeks)		
Have a viral infection		
Have a yeast infection (oral, vaginal etc)		
Have amalgam fillings put IN your teeth		
Have bleeding (which months?)		
Have difficulty with the birth		
Group B Strep Infection		
Use Induction for labor (such as Pitocin)		
Have a C- Section		
Have anesthesia (which one?)		
Use oxygen during labor		
Gestational diabetes		
High blood pressure (pre-eclampsia)		
High blood pressure (toxemia)		
House sprayed for insects		
House painted indoors or outdoors		

Total weight gain during pregancy _____ lb. Total weight loss during pregnancy _____ lb.

Describe your diet during pregnancy: _____

_____

Please describe your labor: _____

_____

Birth Weight and Apgar scores

Weight at birth: _____ lbs. Apgar score at one minute _____ Apgar score at 5 minutes _____

Early Childhood Illnesses

Number of ear infections in the first two years: _____

Number of other infections in the first two years: _____

Number of times child had antibiotics in the first two years of life: _____

Number of courses of prophylactic antibiotics in the first two years of life: _____

First antibiotic at _____ months. First illness at _____ months.

Developmental Milestones

	Approximate Age in months	**Never**	**Did not occur**
Sitting up			
Crawl			
Pulled to stand			
Walked Alone			
Potty Trained			
Dry at Night			
First words			
Spoke clearly			
Lost language			
Lose eye contact			

Did your child display any "cute" or out of the ordinary behaviors when learning to crawl or walk? For example, used to drag one leg, or crawled on all hands and feet with rear end in the air?

_____

_____

_____

Was child breast fed? ☐ Yes ☐ No

Was child bottle fed? ☐ Yes ☐ No

Refused to chew solids ☐ Yes ☐ No

Exclusively breast fed until ☐ Yes ☐ No

Exclusive formula fed until _____

Exclusively soy formula fed until _____

Exclusively milk based formula _____

Introduction of cow's milk at _____

Introduction of rice cereal at _____

Introduction of what and other grains at _____

Does your child have difficulty eating or refuses to eat particular textures, temperatures, or certain kinds of food? ("sensory issues") ☐ Yes ☐ No

If "Yes," please list these foods, textures and temperatures:

_____

_____

_____

Favorite Foods and Drinks:

Breakfast:_____

Lunch_____

Dinner_____

Snacks_____

Beverages_____

Please circle the appropriate number for each item below:

0 as the least/never and 3 as the most/always

Sweets (cookies, candy, sugar)	0 1 2 3
Dairy products (milk, yogurt, cheese, ice cream)	0 1 2 3
Wheat/barley/rye products -breads, pastas	0 1 2 3
Salty foods (potato chips etc)	0 1 2 3
Sweet drinks (Gatorade, Capri Sun, Sunny D, fruit juices)	0 1 2 3

Please circle 'Yes' or 'No' for each question, and Explain where relevant			
Has use of all arms, legs, hands and feet?	Yes	No	_____
Muscle tone is poor/limp	Yes	No	Where?_____
Muscle tone is tense	Yes	No	Where?_____
Hearing loss?	Yes	No	Which ear? _____
Vision loss?	Yes	No	Explain _____
Seizures-focal	Yes	No	
Seizures-generalized	Yes	No	
Seizures-petit mal	Yes	No	
Seizures-grand mal	Yes	No	
Heart murmur	Yes	No	Explain _____
Mitral valve prolapse	Yes	No	
Unusual fast heartbeat	Yes	No	
Age of first period	_____		
Boys: Large testicles	Yes	No	
Early onset breast development	Yes	No	When? _____
Early onset pubic hair	Yes	No	When? _____
Lymph nodes enlarged- neck	Yes	No	
Lymph nodes enlarged- back of head	Yes	No	
Lymph nodes enlarged- elsewhere	Yes	No	
Lymph nodes tender	Yes	No	
Both pupils unusually large	Yes	No	
Both pupils unusually small	Yes	No	
One pupil larger	Yes	No	Which one? _____
Underweight	Yes	No	
Overweight	Yes	No	
Strabismus (crossed eye, lazy eye)	Yes	No	Which eye?
Complains of head pain	Yes	No	
Complains of joint pain	Yes	No	
Complains of leg pain	Yes	No	
Complains of muscle pains	Yes	No	
Odd urinary odor	Yes	No	Explain _____
Odd urine color	Yes	No	Explain _____
Urine hesitancy	Yes	No	
Frequent Urinary tract infections	Yes	No	

Please circle the appropriate number for each item below: 0 as the least/never and 3 as the most/always	
Sensitive to odors, perfumes, smoke	0 1 2 3
Sensitive to pollens, molds	0 1 2 3
Extreme sugar cravings	0 1 2 3
Genital rash (vaginal, “jock itch”)	0 1 2 3
Ringworm	0 1 2 3
Fungus on toenails or fingernails	0 1 2 3
Repeated use of antibiotics (even in distant past)	0 1 2 3
Repeated use of steroids	0 1 2 3
Mouth thrush (yeast infection)	0 1 2 3
Dark skin under eyes; looks like you might have a mild ‘black eye”	0 1 2 3
Bloating	0 1 2 3
Belching	0 1 2 3
Intestinal gas	0 1 2 3
Constipation	0 1 2 3
Diarrhea	0 1 2 3
Indigestion	0 1 2 3
Esophageal reflux	0 1 2 3
Asthma	0 1 2 3
Itching, tingling or burning	0 1 2 3
Hives, psoriasis or dandruff	0 1 2 3
Acne	0 1 2 3
Hair loss	0 1 2 3
Chronic infections (repeated infections)	0 1 2 3
Child’s symptoms/behaviors worse in the following weather: Damp, hot, misty, moldy, musty	0 1 2 3
Bronchitis	0 1 2 3
Congestion with changing seasons	0 1 2 3
Cough	0 1 2 3
Pneumonia	0 1 2 3
Post nasal drip	0 1 2 3
Sighing	0 1 2 3
Sinus fullness	0 1 2 3
Wheezing	0 1 2 3
Child wakes at night laughing, giggling,	0 1 2 3
Child puts pressure on stomach (with hands, laying over arm of couch etc)	0 1 2 3

Please circle ‘Yes’ or ‘No’ for each question, and Explain where relevant			
Blotchy skin	Yes	No	_____
Cellulite	Yes	No	_____
“Chicken skin”, bumpy skin	Yes	No	_____
Cradle cap	Yes	No	_____
Dark birth marks	Yes	No	_____
Diaper rash	Yes	No	_____
Easy bruising	Yes	No	_____
Eczema	Yes	No	_____
Flushing	Yes	No	_____
Odd body odor	Yes	No	_____
Red face	Yes	No	_____
Seborrhea on face	Yes	No	_____
Sensitive to insect bites	Yes	No	_____
Strong body odor	Yes	No	_____
Vitiligo	Yes	No	_____
Dry hair	Yes	No	_____
Dry scalp	Yes	No	_____
Dry skin in general	Yes	No	_____
Feet cracking	Yes	No	_____
Feet peeling	Yes	No	_____
Hands cracking	Yes	No	_____
Hands peeling	Yes	No	_____
Lower dry legs	Yes	No	_____
Nails brittle	Yes	No	_____
Nails frayed	Yes	No	_____
Nails pitted	Yes	No	_____
Nails soft	Yes	No	_____
Ragged cuticles	Yes	No	_____
Thickening fingernails	Yes	No	_____
Thickening toenails	Yes	No	_____
White spots or lines on nails	Yes	No	_____

Abnormal food cravings	Yes	No	_____
Pica (eating non-edible things)	Yes	No	_____
Chew or swallow non-food	Yes	No	_____
Always thirsty	Yes	No	_____
Unusual/extreme water drinking	Yes	No	_____
Behavior is worse with food	Yes	No	_____
Bingeing	Yes	No	_____
Poor appetite	Yes	No	_____
Fissures in rectum or anus	Yes	No	_____
Intestinal parasites	Yes	No	_____
Pinworms	Yes	No	_____
Red ring around anus	Yes	No	_____
Complains of nausea	Yes	No	_____
Stools bulky	Yes	No	_____
Stools light color	Yes	No	_____
Stools very stinky	Yes	No	_____
Stools with blood	Yes	No	_____
Stools with mucus	Yes	No	_____
Stools with undigested food	Yes	No	_____
Stools float in toilet rather than sink	Yes	No	_____
Upper abdominal pain	Yes	No	_____
Vomiting	Yes	No	_____
“Geographic tongue”, looks like a	Yes	No	_____
Gums bleed	Yes	No	_____
Cracking lip corners	Yes	No	_____
Mouth cold sores	Yes	No	_____
Cheek/ear is pink/cold	Yes	No	_____
Cold all over	Yes	No	_____
Cold hands and feet	Yes	No	_____
Cold intolerance	Yes	No	_____
Hands/feet-very sweaty	Yes	No	_____
Head very hot/sweaty	Yes	No	_____
Night sweats	Yes	No	_____
Tip of nose-pink/cold	Yes	No	_____

Please circle the appropriate number for each item below: 0 as the least/never and 3 as the most/always, or Circle "Yes" or "No"	
Grinds teeth	0 1 2 3
Has repetitive movements of some kind (hands, neck, head, voice etc)	Yes No
Complains of Muscle cramps **Where?**	0 1 2 3
Complains of certain muscles that are **always** tight. **Where?**	0 1 2 3
Has small jerks or "twitches" in their muscles. **Where?**	Yes No
Tremors **Where?**	Yes No
Bites or chews fingernails	0 1 2 3
Has Obsessive thoughts	0 1 2 3
Fixated on one topic	
Panic attacks	0 1 2 3
Handwriting gets smaller the more he/she writes	0 1 2 3
Moves slowly compared to how quickly he/she used to move	Yes No
Walking speed is slow (especially compared to how fast he/she used to walk)	Yes No
Child is Excessively motivated	0 1 2 3
Child startles very, very easily	0 1 2 3
Easily embarrassed	0 1 2 3
Feelings of nervousness or anxiety (child may not tell you, but LOOKS this way)	0 1 2 3
Heart pounding, rapid heart rate	0 1 2 3
Complains of not being able to take a deep breath	0 1 2 3
Avoidance of public places from fear or anxiety	0 1 2 3
Unexplained Periods of nausea and stomach upset	0 1 2 3
Tendency to predict the worst	0 1 2 3
Has Fear of being judged or scrutinized	0 1 2 3
Excessive worrying about what others think	0 1 2 3
Tendency to "freeze up" in stressful situations of any kind	0 1 2 3
Holds onto hurts from the past	0 1 2 3
Child is unable to predict actions	0 1 2 3
Act compulsively	0 1 2 3
Hyperactive-move excessively	0 1 2 3
Blurts out thoughts and answers to questions	0 1 2 3
Difficulty remaining seated when expected	0 1 2 3
Easily distracted by ordinary insignificant things	0 1 2 3
Trouble sustaining attention in routine situations	0 1 2 3
Upset if things change	0 1 2 3
Upset if things aren't "right"	0 1 2 3
Adopts complicated rituals	0 1 2 3
Draws accurate pictures	0 1 2 3
Draws only certain things	0 1 2 3
Difficulty modeling someone's behavior. Explain	0 1 2 3
Difficulty making decisions/judgments	0 1 2 3

Please circle the appropriate number for each item below: 0 as the least/never and 3 as the most/always	
Fearful of harmless objects	0 1 2 3
Fearful of unusual events	0 1 2 3
Unaware of danger	0 1 2 3
Unaware of self as a person	0 1 2 3
Very sensitive to pain	0 1 2 3
Insensitive to pain	0 1 2 3
Climbs to high places	0 1 2 3
Likes to be held upside down	0 1 2 3
Likes to be swung in air	0 1 2 3
Whirls self like a top	0 1 2 3
Toe walking	0 1 2 3
Bothered by certain sounds	0 1 2 3
Hearing loss	0 1 2 3
Likes certain sounds	0 1 2 3
Sensitive to loud noise	0 1 2 3
Sounds seems painful	0 1 2 3
Covers ears with sounds	0 1 2 3
Likes to make loud noises with voice	0 1 2 3
Bothered by bright lights	0 1 2 3
Blinking	0 1 2 3
Examines by smell, sniffs things	0 1 2 3
Licks things, puts things in mouth	0 1 2 3
Examines things by sight	0 1 2 3
Light is “calming”	0 1 2 3
Fails to blink at bright light	0 1 2 3
Likes looking at fans	
Likes flickering lights	
Daytime sleepiness	0 1 2 3
Sleeps less than normally expected	0 1 2 3
Sleeps more than normally expected	0 1 2 3
Looks out of corner of eye	0 1 2 3
Child squeezes his/her fingertips	0 1 2 3
Hates wearing shoes	0 1 2 3
Bothered by clothing, tags, etc.	0 1 2 3

Please circle the appropriate number for each item below: 0 as the least/never and 3 as the most/always	
Miss the gist of the story or last to get a joke	0 1 2 3
Tend to write very small	0 1 2 3
Very good at finding mistakes	0 1 2 3
Difficulty remembering where things are	0 1 2 3
Good memory for directions	0 1 2 3
Difficulty understanding body language	0 1 2 3
Difficulty understanding humor and metaphors	0 1 2 3
Difficulty with word problems	0 1 2 3
Difficulty following through or finishing things	0 1 2 3
Good reading comprehension	0 1 2 3
Understands the “big picture” of words/phrases	0 1 2 3
Able to “read between the lines”	0 1 2 3
Appropriate social behavior and responses	0 1 2 3
Able to focus	0 1 2 3
Able to speak without sounding monotone	0 1 2 3
Able to cry or be spontaneous	0 1 2 3
Irregular heart rate (fast or slow)	0 1 2 3
Difficulty changing a set behavior	0 1 2 3
Tend to focus on visual tasks	0 1 2 3
Empathetic-sensitive to other’s feelings	0 1 2 3
Lost in thought, unreachable, “zoned out”	0 1 2 3
Poor eye contact, not as expected	0 1 2 3
Reacts badly to new circumstances	0 1 2 3
Speech sounds monotone	0 1 2 3
Appropriate social behavior	0 1 2 3
Uses one word for another	0 1 2 3
Stumbles over words (gets worse with fatigue)	0 1 2 3
Watches television for a **long** time	0 1 2 3
Plays on a computer for a **long** time	0 1 2 3

Please circle the appropriate number for each item below: 0 as the least/never and 3 as the most/always	
Tantrums	0 1 2 3
OK if parents leave	0 1 2 3
Bold, free of fear	0 1 2 3
Cuddly	0 1 2 3
Happy	0 1 2 3
Likes to be held	0 1 2 3
Likes to be swaddled	0 1 2 3
Sensitive/affectionate	0 1 2 3
Follows instructions as directed	0 1 2 3
Follows multiple step directions well	0 1 2 3
Can do “fine” work well	0 1 2 3
Plays with small object(s)	0 1 2 3
Throws/catches ball well	0 1 2 3
Strong desire to do things	0 1 2 3
Echoes what others say	0 1 2 3
Scripting-repeats videos, movies, etc.	0 1 2 3
Answering questions by repeating question	0 1 2 3
Asks using “you” not “I”	0 1 2 3
Babbling	0 1 2 3
Does not ask questions	0 1 2 3
Expressive language poor	0 1 2 3
Points to objects but can’t name	0 1 2 3
Seems not to understand language	0 1 2 3
Can say “no”	0 1 2 3
Can say “yes”	0 1 2 3
Can say “I”	0 1 2 3
Likes head burrowed	0 1 2 3
Likes head pressed hard	0 1 2 3
Likes head rubbed	0 1 2 3
Likes head under blanket	0 1 2 3

Please circle the appropriate number for each item below: 0 as the least/never and 3 as the most/always, or Circle "Yes" or "No"	
Sees letters backwards	Yes No
Has difficulty with math.	Yes No
Has difficulty with "word" problems in math.	Yes No
Has Difficulty with "spatial" skills	0 1 2 3
Complains of feeling odd sensations (bugs crawling, tingling, burning etc) **Where?**	0 1 2 3
Child has difficulty understanding how others feel .	0 1 2 3
Difficulty understanding people's facial expressions	0 1 2 3
Difficulty interpreting emotional content of a verbal conversation	0 1 2 3
Gets right and left confused.	0 1 2 3
Speech is slurred	0 1 2 3
Child trips.	0 1 2 3
Child knocks over or bumps into objects when reaching for them.	0 1 2 3
Childs drop things.	0 1 2 3

Impossible to discipline	0 1 2 3
Punishment does not work	0 1 2 3
Laughs when being disciplined	0 1 2 3
Nothing seems to interest child	0 1 2 3
Child rarely shows emotion (happy, sad, frustrated)	0 1 2 3
Bed wetting past the age of 4	0 1 2 3
Has "accidents" but doesn't seem to care	0 1 2 3
Does opposite of what is asked	0 1 2 3
Seems to have problem with "authority"	0 1 2 3
Doesn't seem to learn from experience	0 1 2 3
Sudden urges to urinate	0 1 2 3
Increased frequency of urination	0 1 2 3
Argumentative, oppositional behavior	0 1 2 3
Uncooperative, tendency to say no	0 1 2 3
Child lies	0 1 2 3
Child bullies other children / or tries to control others	0 1 2 3

Write down EVERYTHING your child eats/ drink for 48 hours. What you're eating and when you're eating could make your child's symptoms WORSE.

Day 1

Breakfast	Lunch	Dinner
Time: Snack Time:	Time: Snack	Time: Snack

Day 2

Breakfast	Lunch	Dinner
Time: Snack Time:	Time: Snack Time:	Time: Snack Time:

Checklist for Your Completed Packet

___ Affidavit signed by you and members of support system

___ Included your TYPED answers to the questions on page 3.

(Do NOT forget to include these when you mail back.)

___ All questions were answered—no blanks

___ Diet History was completed

___ Your signature on bottom of Diet History page

Mail your completed packet to:

Dr. David Clark, DC

6015 Fayetteville Rd Ste 111

Durham, NC 27713

919-401-0444

or…

Scan all pages of packet (and typed answers) into one pdf file and email to: support@doctordavidclark.com