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OPTIMAL HEALTH & PERFORMANCE

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CLIENT INFORMATION

Date_____

LEGAL NAME_____
Last Name
_____
First Name Middle Name

PREFERRED NAME _____

□ MALE □ FEMALE

D.O.B._____ AGE_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME # (_____) _____

CELL # (_____) _____

CELL CARRIER _____

EMAIL _____

BEST # TO REACH YOU_____

EMPLOYER _____

EMPLOYER ADDRESS _____

_____

EMPLOYER # (_____) _____

OCCUPATION_____

FAMILY PHYSICIAN _____

OFFICE # _____

WHO REFERRED YOU? _____

EMERGENCY CONTACT

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME_____

RELATIONSHIP_____

PHONE # (_____) _____

HISTORY OF COMPLAINT

PRESENT COMPLAINT? _____

_____

WHEN DID IT BEGIN? _____

HOW DID IT BEGIN?

- ☐ IMMEDIATELY AFTER SPECIFIC EVENT
- ☐ GRADUALLY DEVELOPED
- ☐ MULTIPLE EVENTS
- ☐ NO APPARENT REASON
- ☐ OTHER _____

BRIEFLY DESCRIBE INJURY DETAILS _____

_____

_____

IS YOUR PAIN…

- ☐ CONSTANT
- ☐ INTERMITTENT
- ☐ IMPROVING
- ☐ WORSENING
- ☐ NOT CHANGED

MEDICATIONS	ALLERGIES	VITAMINS/SUPPLEMENTS

CLIENT NAME _____ DATE _____

CHECK THE FOLLOWING AS THEY APPLY TO YOU

YES	NO	GENERAL SYMPTOMS & CONDITIONS	YES	NO	GASTRO-INTESTINAL	YES	NO	EAR, NOSE & THROAT	YES	NO	GENITO-URINARY
		Cancer			Nausea			Sore Throat			Painful Urination
		Arthritis			Vomiting			Abrupt Change in Vision			Loss of Bladder Control
		Diabetes			Loss of Bowel Control			Abrupt Change in Hearing			Urinary Tract Infection
		Hepatitis			Ulcers			Glaucoma	**FEMALES ONLY**		
		Kidney Disease			Diarrhea	**RESPIRATORY**					Are you Pregnant
		Fevers			Diverticulitis			Cough	**MUSCLES/JOINTS**		
		Fatigue			Immune System Dysfunction			Tuberculosis			Pain/Swollen Joints
		Bleeding			Unexpected Weight Loss			Lung Disease			Muscle Weakness
		Anemia	**CARDIOVASCULAR**					Difficulty Breathing			Scoliosis
		HIV/AIDS			High Blood Pressure			Allergies			Numbness
		Rash			Strokes			Respiratory Infection			Joint Replacement
		Dizziness			Heart Disease	**INJURIES/FRACTURES**					
		Bruises Easily			Poor Circulation				Year		
		Thyroid Disease			Pacemaker				Year		
		Hot Flashes			Chest Pain				Year		
NEUROLOGICAL					On Blood Thinners	**SURGERIES/HOSPITALIZATIONS**					
		Anxiety	**LIFESTYLE HABITS**						Year		
		Depression			Caffeine Beverages				Year		
		Seizures	How Many Per Day _____						Year		
		M.S.			Tobacco Use				Year		
		Memory Loss	Packs Per Day _____			**CURRENT WORK STATUS**					
		Difficulty Sleeping	How Long _____			Years in Position:			Total Hours:		
		Night Sweats			Alcohol Use			Driving			Lifting
		Headaches			Regular Exercise			Standing	Average Weight _____lbs.		
How Often Are Your Headaches?			How Often Do You Exercise?					Sitting	Lifting How Often?		
Severity (Circle) 0 1 2 3 4 5 6 7 8 9 10					Has Your Complaint Prevented You from Exercising?						
			When Was the Last Time You Were Able to Exercise Regularly?								

OTHER ISSUES NOT LISTED

FAMILY HISTORY

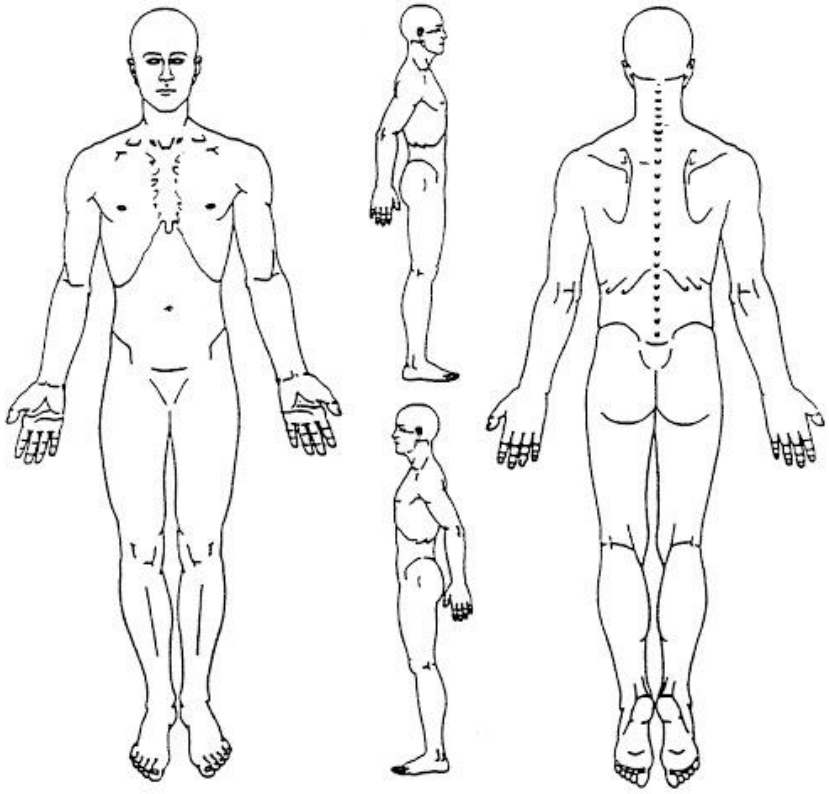
	Abnormal Bleeding	High Blood Pressure	Heart Disease	Cancer	Muscle Disease	Diabetes	Drug Allergies	Food Allergies	Rheumatoid Arthritis	Scoliosis	Osteo Arthritis	Deceased	Deceased At What Age?
Father													
Mother													
Brother													
Sister													
Child													

CLIENT NAME_____ DATE _____

MAJOR COMPLAINT INFORMATION

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing. If pain is radiating, please draw an arrow indicating to where it travels.

A = Ache **O = Other**
B = Burning **P = Pins and Needles**
N = Numbness **S = Stabbing**



COMPLAINT
Have you had this in the past? □ Yes □ No

If "YES", please describe
_____
_____
_____
_____
_____

Is it getting worse?
□ Yes □ No □Constant

TYPE OF PAIN
□ Aching □ Sore □ Burning
□ Shooting □ Deep □ Throbbing
□ Dull □ Pulling □ Numb
□ Stabbing □ Tight □ Throbbing
□ Sharp □ Stiff □ Tender
□Tingling □ Annoying

Result of:
□ Auto Accident
□ Work Injury
□ Other: _____
_____
_____

WORSE WITH WHICH ACTIVITY?
□ Lying on Back □ Stooping
□ Lying on Side □ Bending
□ Lying on Stomach □ Walking
□ Turning Over □ Sitting
□ Getting in/out of car □ Twisting/ Turning
□ Dressing Self □ Coughing
□ Pushing □ Standing
□ Pulling □ Climbing
□ Lifting □ Sneezing
□ Reaching
□ Other_____

BETTER WITH WHICH ACTIVITY?
□ Lying on Back
□ Stooping
□ Lying on Side
□ Bending
□ Lying on Stomach
□ Walking

Other_____
_____
_____
_____

HOW WOULD YOU RATE YOUR COMPLAINT TODAY? (Circle)

None

0 1 2 3 4 5 6 7 8 9 10

Most Severe

HOW WOULD YOU RATE YOUR COMPLAINT ON AVERAGE? (Circle)

None

0 1 2 3 4 5 6 7 8 9 10

Most Severe

PREVIOUS TREATMENT FOR THIS COMPLAINT?
□ Massage Therapy
□ Physical Therapy
□ Family Physician
□ Surgery
□ Chiropractor
What was the treatment?
_____

Did it work? If so, how long?
_____

PRIOR IMAGING/TESTING FOR THIS COMPLAINT?
□ X-Ray's
□ MRI
□ Lab
What have you been told was wrong?
_____
_____

CLIENT NAME _____ DATE _____

NOTICE OF PRIVACY PRACTICES (HIPPA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Optimal Health & Performance is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

- Treatment: Optimal Health & Performance may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment.
- Worker's Compensation: Optimal Health & Performance may disclose health information as necessary to comply with state worker's compensation laws.
- Emergencies: Optimal Health & Performance may disclose your health information to notify or assist in notifying a family member or person responsible for your care about your medical condition or in the event of an emergency.
- Public Health: As required by law, Optimal Health & Performance may disclose health information to public health authorities for purposes related to; preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration for problems with products and reactions to medications, and reporting disease or infection exposure.
- Judicial and Administrative Proceedings: Optimal Health & Performance may disclose your health information in the course of any administrative or judicial proceedings.
- Law Enforcement: Optimal Health & Performance may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena , and other law enforcement purposes.
- Deceased Persons: Optimal Health & Performance may disclose your health information to coroners or medical examiners.
- Research: Optimal Health & Performance may disclose your health information to researchers conducting research that has been approved by an institutional review board.
- Public Safety: It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.
- Specialized Government Agencies: Optimal Health & Performance may disclose health information for military, national security, prisoner and government benefit purposes.
- Change of Ownership: In the event that Optimal Health & Performance is sold or merged with another organization, your health information and record will become the property of the new owner.

MARKETING

We may contact you for marketing purposes, as described below:

- As a courtesy to our patients, it is our policy to call you the day prior to your scheduled appointment to remind you of your appointment times. If you do not answer, we will leave a reminder message on you answering machine or with the person answering the phone. No personal health information will be disclosed during this message other than the date and time of your schedule appointment along with a request to call our office if you need to cancel or reschedule your appointment.
- As a service to our patients, it is Optimal Health & Performance's policy to occasionally send a health newsletter or flyer, regarding upcoming health classes or events offered on the premises or organized by Optimal Health & Performance. It is not policy to disclose any personal health information about your condition for the purposes of these marketing mailings. Occasionally Optimal Health & performance will send birthday or holiday greetings or health reminders to patients. It is not policy to disclose any personal health information about your condition in these mailings.

YOUR HEALTH INFORMANTION RIGHTS

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised however, that Optimal Health & Performance is not required to agree to the restriction(s) that you request.
- You have the right to have your health information received or communicated through an alternative method when sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have the right to request that Optimal Health & Performance amend your protected health information. Please be advised however, that Optimal Health & Performance is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of denial and information about how you can appeal.
- You have the right to a paper copy of this notice of privacy practices at any time, upon request.

NOTICE OF PRIVACY PRACTICES (HIPPA) CONTINUED

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

- Optimal Health & Performance reserves the right to amend this notice of privacy practice at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, Optimal Health & Performance is required by law to comply with this notice. Optimal Health & Performance is also required by law to maintain the privacy practices with respect to your health information and to provide you with notice of its legal duties. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact Optimal Health & Performance by calling 931.651.1390.

COMPLAINTS

- Complaints about your privacy rights or how your health information has been handled should be directed to Optimal Health & Performance, at 931.651.1390.
- If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:
  CHHS, Office of Civil Rights
  200 Independence Ave, S.W.
  Room 509F HHH Building
  Washington, DC 20201

I have read the Notice of Privacy Practices (HIPPA) and understand my rights contained in the notice.
By way of my signature below, I provide Optimal Health & Performance with my authorization and consent to use and disclose my protected health information for the purpose of treatment, payment and health care operations as described in the Privacy Notice.

_____	_____	_____	_____
CLIENT NAME (PRINT)		**CLIENT SIGNATURE**	**DATE**

_____	_____
AUTHORIZED FACILITY SIGNATURE	**DATE**

FEE SCHEDULE

INITIAL EXAM ……..……. $120

MINOR (10 & UNDER) INITIAL EXAM ……...…….$25- $50

ACTIVE MOVEMENT THERAPY* ……...……. $60

MINOR (10 & UNDER) ACTIVE MOVEMENT THERAPY ……..……...…. $15-$25

INTRAMUSCULAR STIMULATION (IMS) ……... $60
"DRY-NEEDLING"

ACTIVE MOVEMENT THERAPY + IMS ……...……..... $75

PAIN LASER THERAPY ……... $15

MUSCLE STIM AND/OR RECOVERY ……..……. $15

KINESIOTAPE (ROCKTAPE) APPLICATION ……..……. $15-$40

DEEP TISSUE AND THERAPEUTIC MASSAGE ……....…. $40- $130

*Active Movement Therapy may include spinal manipulation, extremity manipulation, myofascial release, therapeutic/corrective exercise(s), and/or postural correction.

**Fee may vary upon physician discretion, minors aged 11 and up will be charged the adult rate unless otherwise determined by the physician.

PAYMENT AGREEMENT

All fees are due at the time services are rendered. For your convenience, Optimal Health and Performance accepts cash, debit, checks, HSA/HRA accounts, Visa, Mastercard, Discover and American Express. Appointments missed or cancelled without providing 24hours notice are subject to a $25 fee. There will also be a $35 service charge on all returned checks. Optimal Health and Performance is a wellness and performance clinic and therefore, does not accept insurance or provide medical coding for reimbursement.

_____	_____	_____
CLIENT SIGNATURE	DATE	CLIENT NAME (PRINTED)

INFORMED CONSENT FOR THE PURPOSE OF TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the client named below, for whom I am legally responsible) by Optimal Health & Performance and/or other licensed Doctors of Chiropractic who now, or in the future, treat me while employed by, working or associated with or serving as back up for the chiropractic physician.

I have had an opportunity to discuss with the Doctor of Chiropractic, and/or with other office or clinic personnel with Optimal Health & Performance, the nature and purpose of chiropractic adjustments and procedures. I understand and I am informed that, as with all healthcare treatments, results are not guaranteed. I further understand and I am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including but not limited to; muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack of improvement in symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctors feel at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent condition(s) for which I seek treatment.

_____	_____	_____
CLIENT/PARENT/GUARDIAN-SIGNATURE	**DATE**	**CLIENT/PARENT/GUARDIAN (PRINT)**
_____		_____
NAME OF CLIENT IF UNDER 18 YEARS OF AGE		**AUTHORIZED FACILITY SIGNATURE**

INFORMED CONSENT FOR THE PURPOSE OF INTRAMUSCULAR STIMULATION (DRY NEEDLING)

I hereby request and consent to the treatment of Intramuscular Stimulation (IMS) also known as Dry Needling, on me (or on the client named below, for whom I am legally responsible) by the Optimal Health & Performance trained chiropractic physician and/or other licensed doctors of chiropractic who now, or in the future, treat me while employed by, working or associated with or serving as back-up for the chiropractic physician with qualified training as stated within the scope of practice for chiropractic physicians in the state of Tennessee. (Title 63 Professions of the Healing Arts, Chapter 4 Chiropractors, TENN. Code Ann 63-4-101 and by the Board of Tn Chiropractic Examiners).

I have had an opportunity to discuss with the Doctor of Chiropractic, and/or with other office or clinic personnel of Optimal Health & Performance, the nature and purpose of IMS and procedures. I understand and am informed that, as with all healthcare treatments, results are not guaranteed. I further understand and I am informed that, as is with all healthcare treatments, in the practice of IMS via a chiropractic physician there are some risks to treatment, including but not limited to, muscle spasms for sort periods of time, aggravating and/or temporary increase in symptoms, lack of improvement in symptoms, bruising, local swelling and pneumothorax. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feel at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____	_____	_____
CLIENT/PARENT/GUARDIAN SIGNATURE	**DATE**	**CLIENT/PARENT/GUARDIAN (PRINT)**
_____		_____
NAME OF CLIENT IF UNDER 18 YEARS OF AGE		**AUTHORIZED FACILITY SIGNATURE**

INFORMED CONSENT FOR THE PURPOSE OF MASSAGE THERAPY

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. Draping will be used during the session, meaning only the area being worked on will be uncovered. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of.

I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

_____ _____ _____

CLIENT/PARENT/GUARDIAN (SIGNATURE **DATE** **CLIENT/PARENT/GUARDIAN (PRINT)**

_____ _____

NAME OF CLIENT IF UNDER 18 YEARS OF AGE **AUTHORIZED FACILITY SIGNATURE**

INFORMED CONSENT FOR THE PURPOSE OF CUPPING THERAPY

Cupping therapy is a form of alternative medicine in which a local suction is created on the skin with the application of cups.

I confirm that the cupping therapy practitioner has fully explained to me the benefits, side effects and contraindications of cupping therapy, and that I understand that some degree of skin marking or bruising, lasting between 10 and 20 days, may result. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. I further understand that cupping should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

_____ _____ _____

CLIENT/PARENT/GUARDIAN (SIGNATURE **DATE** **CLIENT/PARENT/GUARDIAN (PRINT)**

_____ _____

NAME OF CLIENT IF UNDER 18 YEARS OF AGE **AUTHORIZED FACILITY SIGNATURE**