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OPTIMAL HEALTH & PERFORMANCE

13 N. OAK AVENUE, COOKEVILLE, TN 38501 | 931.651.1390 OHANDP@GMAIL.COM

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 # (_____) _____

EMAIL _____

BEST # TO REACH YOU_____

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? (CIRCLE)

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

BRIEFLY DESCRIBE INJURY DETAILS _____

_____

_____

IS YOUR PAIN (CIRCLE)

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

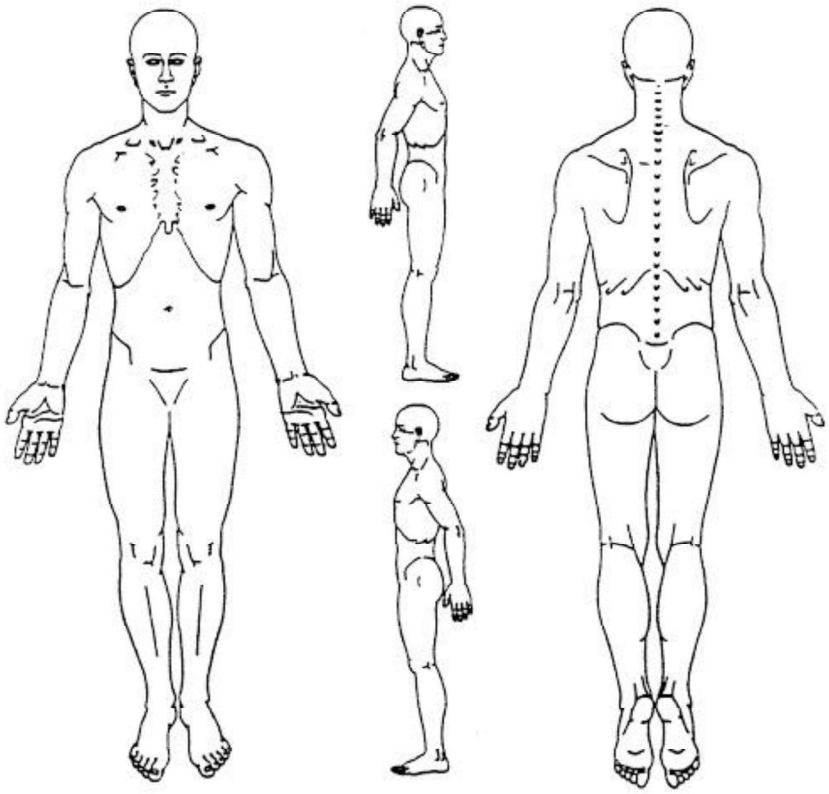
ADDITIONAL MEDICATIONS

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	TYPE OF PAIN	WORSE WITH WHICH ACTIVITY?	BETTER WITH WHICH ACTIVITY?
Have you had this in the past? □ Yes □ No If "YES", please describe _____ _____ _____ _____ _____ Is it getting worse? □ Yes □ No □Constant	□ Aching □ Sore □ Burning □ Shooting □ Deep □ Throbbing □ Dull □ Pulling □ Numb □ Stabbing □ Tight □ Throbbing □ Sharp □ Stiff □ Tender □Tingling □ Annoying **Result of:** □ Auto Accident □ Work Injury □ Other: _____ _____ _____	□ 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_____	□ Lying on Back □ Stooping □ Lying on Side □ Bending □ Lying on Stomach □ Walking Other_____ _____ _____ _____

HOW WOULD YOU RATE YOUR COMPLAINT TODAY? (Circle)	HOW WOULD YOU RATE YOUR COMPLAINT ON AVERAGE? (Circle)	PREVIOUS TREATMENT FOR THIS COMPLAINT?	PRIOR IMAGING/TESTING FOR THIS COMPLAINT?
None 0 1 2 3 4 5 6 7 8 9 10 Most Severe	None 0 1 2 3 4 5 6 7 8 9 10 Most Severe	□ Massage Therapy □ Physical Therapy □ Family Physician □ Surgery □ Chiropractor What was the treatment? _____ Did it work? If so, how long? _____	□ X-Ray's □ MRI □ Lab What have you been told was wrong? _____ _____

CLIENT NAME _____ DATE _____

NOTICE OF PRIVACY PRACTICES (HIPPA)

EFFECTIVE DATE: NOVEMBER 19, 2025

At Optimal Health & Performance (OHP), we are committed to protecting the privacy and security of your health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA). This policy outlines how we handle your Protected Health Information (PHI).

Use and Disclosure of PHI for the Following Purposes:

- Treatment: To provide, coordinate, or manage your care (e.g., sharing information with your referring physician, other professionals within our practice for the purpose of treatment).
- Emergencies: To notify or assist in notifying a family member or person responsible for your care about your medical condition in the event of an emergency.
- Law Enforcement: For the purposes of identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order subpoena, and other law enforcement purposes.
- Judicial & Administrative Proceedings: During any administrative or judicial proceedings.

We will not use or disclose your PHI for any other purpose without your written authorization, unless required or permitted by law.

Safeguards: We implement physical, administrative, and technical safeguards to protect your PHI from unauthorized access, use, or disclosure.

Your Rights:

- Access and request a copy of your health records.
- Request corrections to your records.
- Receive an accounting of disclosures.
- Request restrictions on certain uses or disclosures.
- Request confidential communications.
- File a complaint if you believe your privacy rights have been violated.

Changes to this Notice of Privacy Practices: Optimal Health & Performance reserves the right to amend this notice of privacy at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendments are made, OHP is required by law to comply with this notice. OHP 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.

Contact: If you have questions about this policy or wish to exercise your rights, please contact our Privacy Officer at: Optimal Health & Performance | 931-651-1390 | OHandP@gmail.com | 13 N. Oak Ave. Cookeville, TN 38501

I have read the Notice of Privacy Practices (HIPPA) and understand my rights contained in the notice. By way of my signature below, I provided 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 SIGNATURE	CLIENT NAME (PRINT)	DATE

_____
OHP STAFF SIGNATURE

FEE SCHEDULE

INITIAL EXAM ……..……. $140

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

ACTIVE MOVEMENT THERAPY* ……...……. $70

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

INTRAMUSCULAR STIMULATION (IMS) ……... $70
"DRY-NEEDLING"

ACTIVE MOVEMENT THERAPY + IMS ……..……... $85

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 who no-show will be charged a 50% fee of the scheduled service. 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	**OHP STAFF 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	**OHP STAFF 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 **OHP STAFF 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 **OHP STAFF SIGNATURE**