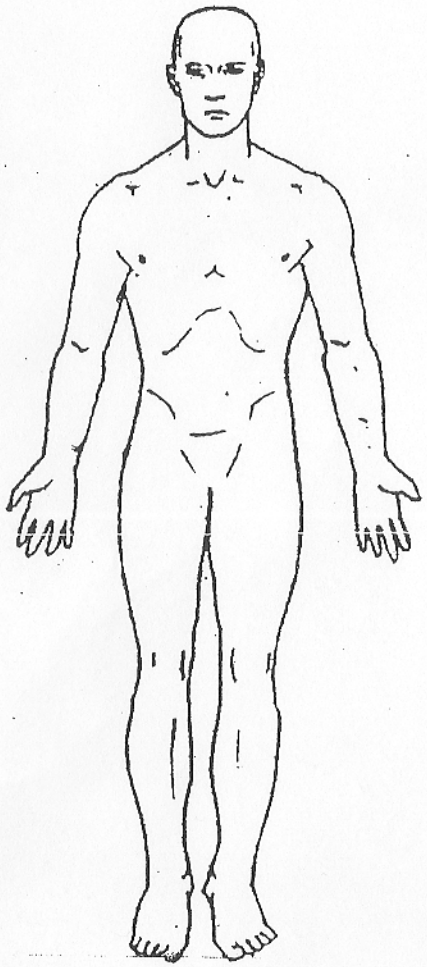
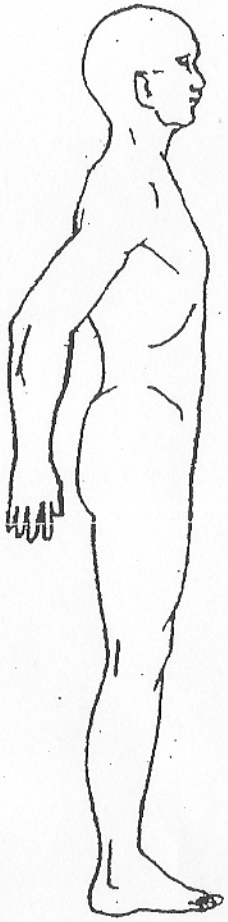
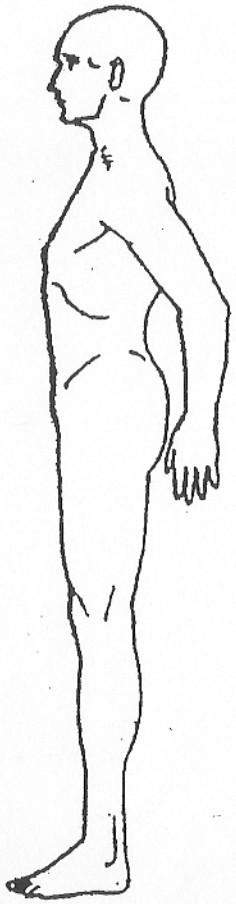
Optimum Performance Center

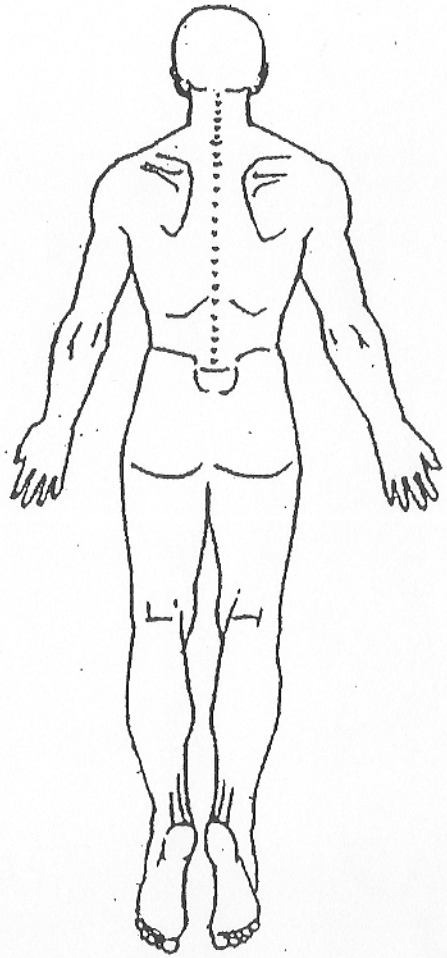
Name: _____ Date: __/__/_____

Please shade in all points or areas that have been a problem in the past or currently.









Optimum Performance Center 10 NE 11 Ave. Fort Lauderdale, FL. 33301 954 463 5250 results@DennisPriceTherapy.com

Confidential Case History

Day phone:_____

Name:_____ Cell phone:_____

Address:_____ City:_____ State:____ Zip:_____

Date of Birth: __/__/__ Age: _____ M___/F___ Marital Status:_____ No of children:_____

E-mail:_____Occupation:_____ Referred by:_____

Reason for visit:_____

_____

Present symptoms / Primary pain or complaint-_____

_____

Past symptoms / Other areas of concern:_____

_____

When did you 1st notice primary symptoms? _____

What brought it on? _____

What makes it worse? _____

Is this interrupting your: work_____ sleep _____ other daily activities _____

Have you seen a physician? Y / N; If yes, what type? _____

Have you had: X-Rays _____ MRI _____ CT Scan _____ Blood work _____ Urine tests _____ Saliva tests_____ Other _____

What were the test results? _____

Has a diagnosis been assigned to your condition? Y / N If yes, what name? _____

Do you have other medical conditions? Heart____ Lungs____ Colon____ Stomach____ Liver____ Kidneys____ other_____

Have you had surgery? Y / N; If yes, what type? _____

_____

What was the result? _____

Have you had therapy? Y / N; If yes, what type? _____

If therapy, how many treatments over what time period? _____

How much relief have you experienced? _____

Do you wear orthotics? Y / N If yes, what type? Feet _____ Jaw _____ other _____

Do you take: Prescription meds____ herbs____ vitamins____ minerals____ homeopathic remedies____ other____

If yes, please list: _____

Have you had broken bones of other prior injuries? Y / N; If yes, what type? _____

_____

What is your past exercise history? _____

What is your current level of activity? _____

For how long? _____

What is your expectation of this program?_____

I agree that the above statements are true and correct to the best of my knowledge. I agree to take responsibility for improving this condition. I understand that I am requesting a specific program for the above condition based on a detailed evaluation. I can expect a clear, detailed explanation of the program so that I understand how it will impact my current condition. I understand that this program may involve nutrition and/or lifestyle considerations to the degree that it affects my condition as stated above. I agree to follow through with this program to the best of my ability, with the expectation of improvement. I agree to the financial responsibility for this program, and understand that any attempt to obtain insurance reimbursement is an additional benefit and in no way alters my financial responsibility.

Signed:_____ Date:_____

OPTIMUM PERFORMANCE TRAINING

Name:_____ Date:_____

Visceral (Stress)

Do you have or have you ever had problems with the following?

C=current P=past *If a family member has / has had same, please note as:
M- mother, F- father, GM- grandmother, GF- grandfather, S- sister, B- brother

Liver ____ Kidneys____ Gall bladder____ Spleen____ Stomach____
Pancreas____ Lungs____ Heart____ Ovaries____ Testicles____
Bladder____ Urinary tract____ Anus____ Small intestine____ Colon____

Hormonal (Stress)

Please rate the following on a scale of 1-10, (1=lowest - 10=highest)

Energy level? _____
Concentration level? _____
Cravings? _____
Body temperature? _____
Sweating? _____
Bloating / water retention? _____
Sex drive? _____
Restful, good night's sleep? _____
*Times waking / night ___ Hours sleeping / night ___ Hours sleeping / week ___

Emotional (Stress)

Please rate the following on a scale of 1-10, (1=lowest - 10=highest)

General stress levels in life: _____

Work stress: Productivity- _____
$ -Income- _____
Work relationships- _____

Domestic stress: Communication- _____
Bills- _____
Sex life- _____

Anti-Social ---------- Social: _____

Motivation level: _____

Appetite: _____