

OPTI-STRENGTH SYSTEMS

CLIENT REGISTRATION FORM

Today's date:

Referred by:

CLIENT INFORMATION-

Have you been seen before or other family members seen here?

Have you visited my website? Optistrengthsystems.com yes or no

Last Name:

First Name:

Birthdate:

Age:

Weight:

Height:

Employer:

CONTACT INFORMATION-

Email address:

Mailing address:

Cell phone:

Home phone:

Emergency contact name and phone:

FEE AND PAYMENT INFORMATION-

NOTE: Opti-Strength is NOT a medical facility. A medical diagnosis will NOT be made, and we cannot accept or bill your insurance.

A commitment is not made until you have enrolled in a prepaid therapy program. If not enrolling in a program, you will be charged an individual fee per each appointment.

Payment of applicable fees are due in advance or at the time or your therapy session. Opti-Strength does not have the capability for insurance billing, but you will be provided with a printed receipt upon request. Standard enrollment includes **six (6)** prepaid appointments.

Refunds for unused sessions will not be granted beyond one (1) year from program initiation date.

The above information is true to the best of my knowledge. I understand that I am financially responsible for my treatment.

Signature: _____ Date: _____

OPTI-STRENGTH SYSTEMS

MEDICAL HISTORY AND WAIVER OF LIABILITY

Have you experienced any of the following: Use the back side of sheet to explain any questions.

- Y or N Heart attack, coronary bypass, or other coronary surgery
- Y or N Chest discomfort (especially with exertion)
- Y or N High blood pressure
- Y or N Rapid heartbeats or palpitations
- Y or N Unusual cardiac findings
- Y or N Peripheral vascular disease
- Y or N Phlebitis
- Y or N Shortness of breath that is unusual
- Y or N Light headedness or fainting
- Y or N Pulmonary disease- ie. (asthma, emphysema, bronchitis)
- Y or N High cholesterol
- Y or N Stroke
- Y or N Recent hospitalization for illness or surgery-list on back of sheet
- Y or N Are you taking any medications-list on back of sheet
- Y or N Are you diabetic Is it controlled
- Y or N Are you pregnant now
- Y or N Is there any reason your physician would object to your exercising
- Y or N Do you have any areas of pain in your body currently, either chronic or new pain- list details on back of sheet

I, the undersigned, have read, understand, and have answered the above health/medical questions fully and truthfully. I do hereby intend to be legally bound for myself and waive release of any, and all rights and claims for damages I may have against Opti-Strength Systems, this facility and D. Clay Ward, the therapist administering this instrument for any, and all injuries suffered while this program is provided by me.

CLIENT _____ DATE _____

D. Clay Ward, F.T.C.