Welcome to Transformation Health! Our first step towards helping you move towards greater health and vitality after your automobile accident is to find out more about you. Please fill out the following information regarding your accident, your health, your life and your overall well being. Chiropractic care focuses on you as a whole person, not only on your specific problems. All our life's experiences make us who we are today, so the more information you can provide us with, the better we will be able to serve you!

After the initial consultation, a chiropractic assessment will thoroughly evaluate your spine and nervous system to determine your need for care. After Dr. Trupp reviews and studies your results, your next visit will share the findings of this assessment, explain our recommendations and give you a complete action plan to optimize your health and to allow you to live life more fully!

Part of our commitment is to provide as much information as possible about health, healing and well being. Each new person who begins care is required to attend a Doctor's Report. It is included in the price of your first visit and will greatly enhance your experience, as well as help you get the most value for your investment. Your spouse / significant other or a family member / friend must attend with you to help support you in your health goals! In addition, we have regular workshops that will contribute to enhancing your day-to-day life.

Our mission is to serve every human being with love, honor and respect. The staff at Transformation Health is a team, and we take great pride in our training, knowledge and capability to help our patients. We provide life-enhancing chiropractic care to all ages in an environment which encourages people to commit to their continued well being and empowers them to maximize their human potential.

Once again, welcome to Transformation Health! We look forward to helping you and your family achieve outrageous health and vitality. We are honored to serve you!

In Good Health,

Dr. C.J. Trupp III

33523 Eight Mile Road ~ Livonia, MI 48152
(248) 488-7500 ~ (248) 488~7501 fax
www.TransformationHealthAndWellness.com

AUTOMOBILE ACCIDENT PATIENT INFORMATION

Name_____ Date_____

Address_____

City_____ State_____ Zip_____

E-mail Address _____

Home Phone_____ Work Phone_____ Cell Phone_____

Date Of Birth_____ Social Security Number _____

Driver's License Number_____ Sex ☐ M ☐ F ☐ T Height _____ Weight _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Race ☐ White ☐ Black or African American ☐ Other _____

Primary Language ☐ English ☐ Other _____

Employer_____

Address_____

City_____ State_____ Zip_____

Occupation_____ ☐ Full Time ☐ Part Time

Spouse's Name_____ Date of Birth_____

Spouse's Employer_____

Children(s) Name(s) – Age(s) _____

Are You Currently Pregnant? ☐ No ☐ Yes #Weeks_____ Referred By_____

Primary Care Physician's Name / Address / Phone _____

_____

Insurance Information

Primary Insurance Company Name_____

Contract Number_____ Policy / Group Number_____

Complete The Following Only If The Patient Is Not The Insured:

Insured's Name_____ Patient's Relationship To Insured_____

Insured's Date of Birth_____ Insured's Employer_____

Secondary Insurance Company Name_____

Contract Number_____ Policy / Group Number_____

Complete The Following Only If The Patient Is Not The Insured:

Insured's Name_____ Patient's Relationship To Insured_____

Insured's Date of Birth_____ Insured's Employer_____

History

Date Of Accident _____

Explain In Detail How Your Accident Happened _____

_____

_____

Have You Retained An Attorney? ☐ Yes ☐ No If Yes, List Name _____

What Direction Were You Heading? _____ On _____ (Street / Highway)

What Direction Was The Other Vehicle Heading? _____ On _____(Street / Highway)

Were The Police Notified? ☐ Yes ☐ No

Were You Knocked Unconscious? ☐ Yes ☐ No If Yes, How Long _____

Where Were You Struck From? ☐ Front ☐ Back ☐ Left ☐ Right

Were You ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat ☐ Using Safety Belt

When Did You Begin To Feel Pain (Date And Time)? _____

Where Did You Feel The Pain? _____

Where Were You Taken After The Accident? _____

What Treatment Was Given? _____

What Was The Name Of The Doctor You Consulted? _____ ☐ M.D. ☐ D.O. ☐ D.D.S.

What Was The Diagnosis / Recommended Treatment? _____

How Often Did You See The Doctor? _____

How Long Did You See The Doctor? _____

Have You Ever Had Any Complaints In The Involved Area? ☐ Yes ☐ No

If Yes, What Were They? _____

Before The Accident, Were You Capable Of Working On An Equal Basis With Others Your Age? ☐ Yes ☐ No

Are Your Work Activities Restricted As A Result Of This Accident? ☐ Yes ☐ No

Since This Injury Are Your Symptoms ☐ Improving ☐ Getting Worse ☐ Staying The Same

What Surgeries Have You Had? _____

List All Medications / Nutritional Supplements You Are Now Taking (Prescription & Non-Prescription) _____

_____

Please Mark If You Have Had Any Of These Symptoms In The Last Twelve Months:

- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Auto Accident
- ☐ Blurred / Double Vision
- ☐ Cancer
- ☐ Concentration Problems
- ☐ Constipation
- ☐ Convulsions / Seizures
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Digestive Problems
- ☐ Dizziness
- ☐ Ear Infections
- ☐ Eating Disorder
- ☐ Foot Problems R L
- ☐ Fractured Bones
- ☐ Frequent Colds / Flu
- ☐ Gall Bladder Problems
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Problems
- ☐ High / Low Blood Pressure
- ☐ Hip Pain R L
- ☐ HIV / AIDS
- ☐ Impotence
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Lower Back Pain / Stiffness
- ☐ Mid Back Pain / Stiffness
- ☐ Mood Swings
- ☐ Neck Pain / Stiffness
- ☐ Numbness / Tingling (Arms / Fingers / Hands)
- ☐ Numbness / Tingling (Buttocks / Legs / Feet / Toes)
- ☐ Other Accidents / Falls
- ☐ Painful Cough / Sneeze
- ☐ PMS
- ☐ Pneumonia
- ☐ Polio
- ☐ Pregnant (Presently)
- ☐ Prostate Problems
- ☐ Ringing In Ears R L
- ☐ Shoulder Pain R L
- ☐ Skin Problems
- ☐ Sleep Problems
- ☐ Stress
- ☐ Stroke
- ☐ TMJ / Jaw Pain
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Upper Back Pain / Stiffness

This is to certify that to the best of my knowledge I am not pregnant, and the staff of Trupp Transformation Health, PLLC has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

_____	_____	_____
Date of Last Menstrual Period	Patient Signature	Date

NOTICE OF PRIVACY PRACTICES

See our Notice of Privacy Practices displayed in our reception area. I understand that I have reviewed and authorize you to use or disclose my health information in the manners described in the notice. Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules. I am also acknowledging that I have received a copy of the Notice of Privacy Practices.

Trupp Transformation Health, PLLC has semi-private adjusting rooms. These areas are not confidential. During adjustments, we do not go over private information; however, you will be in an open area where others may see you and / or overhear conversation. If there is a need to discuss something of a personal or private nature, you may request an appointment in a confidential area.

Authorization For Disclosure Of Information

I, _____, hereby authorize Trupp Transformation Health, PLLC to disclose or discuss the following protected health information:

_____ all protected health information (no limitations)

_____ limited to the following listed information: _____

_____

This protected health information may be released to:

_____

Print name Relationship

_____

Print name Relationship

This notice is effective as of October 4, 2010. This notice will expire seven years after the date on which you last received services from us. I understand that I have the right to revoke this, in writing, at any time by sending written notification to the above listed address. By signing below, I acknowledge that a copy of this notice has been made available to me.

_____ _____

Patient Name Printed Date

_____ _____

Patient Signature Authorized Provider Representative

_____ _____

Personal Representative Printed Personal Representative Signature

_____

Description Of Personal Representative's Authority To Act For This Patient

_____ Copy Given To Patient

TTH Staff Initial Here

POLICIES

1. All first visit charges are payable when services are rendered.

2. Method of payment you plan to use to take care of today's charges?

   ☐ Cash ☐ Check ($35 nsf check fee) ☐ MasterCard ☐ Visa

3. The fee paid for x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released. If requested, a detailed report with the radiological analysis will be provided to you at no charge.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. In the specific cases where Trupp Transformation Health, PLLC bills my insurance carrier directly, I understand that Trupp Transformation Health, PLLC will prepare all necessary reports and forms to assist in making collections from the insurance company. I hereby authorize payment to be made directly to Trupp Transformation Health, PLLC, of all benefits which may be due and payable under insurance coverage for the below named patient and that any amount authorized to be paid directly to Trupp Transformation Health, PLLC will be credited to my account upon receipt. I authorize utilization of this application or copies therefore for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and I clearly understand and agree that all of the services rendered to me are charged directly to me and that I am personally financially responsible for payment including any deductibles and / or co payments to Trupp Transformation Health, PLLC.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect on this account.

Trupp Transformation Health, PLLC is hereby authorized to disclose all or any part of the medical records for the below patient to such insurance companies, organizations or agencies as to whom may be responsible for payment of services rendered by Trupp Transformation Health, PLLC. I give this authorization with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by Trupp Transformation Health, PLLC.

The undersigned certifies that he / she has read and understands each of the above statements and is the patient or responsible party with the power to execute this document and accept these terms.

Patient Signature Date

In Case Of Emergency, Notify Relationship Phone Number

Address

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the neurospinal system.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our ONLY practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____	_____
Patient Name Printed	Date
_____	_____
Patient Signature	Authorized Provider Representative
_____	_____
Personal Representative Printed	Personal Representative Signature

_____
Description of Personal Representative's Authority To Act For This Patient

