Welcome to Transformation Health! Our first step towards helping your child move towards greater health and vitality is to find out more about them. Please fill out the following information regarding their health, their life and their overall well being. Chiropractic care focuses on your child as a whole person, not only on their 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 and your child!

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

CHILD PATIENT INFORMATION

General Information

Name_____Date_____

Parent/s Name/s _____

Address_____

City_____State_____Zip_____

E-mail Address _____

Home Phone_____Work Phone_____Cell Phone_____

Date Of Birth_____Social Security Number _____

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

Race ☐ White ☐ Black or African American ☐ Other _____

Primary Language ☐ English ☐ Other _____

Sibling/s Name/s – Age/s _____

Is Your Child 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_____

Pregnancy / Birth History

Were There Any Traumas Or Illnesses During Pregnancy? _____

During Pregnancy, Did The Mother Consume Alcoholic Beverages Or Smoke? If Yes, How Much? _____

Were Any Medications / Supplements Taken During The Pregnancy (Prescription & Non-Prescription)? If Yes, Please List: _____

_____

Were Any Ultrasounds Or Other Radiation Used During The Pregnancy? If Yes, Please List How Many And For What Reasons:____

_____

Was The Labor Induced? ☐ Yes ☐ No Duration Of Labor? _____

Were Any Medications Used During Labor / Delivery? If Yes, Please List: _____

Were There Any Complications During Labor / Delivery? If Yes, Please List: _____

_____

Type Of Delivery ☐ Breech (Feet First) ☐ Cephalic (Head First) ☐ Cesarean Section ☐ Forceps ☐ Vacuum Extraction

Location Of Birth ☐ Home ☐ Birthing Center ☐ Hospital

Was Your Child Subjected To Any Of The Following? ☐ Hepatitis Shot ☐ Silver Nitrate Eye Drops ☐ Vitamin K Shot

Were Vaccinations Given? If Yes, Were There Any Adverse Reactions? _____

_____

Was Your Child Breast Fed? If Yes, For How Long? _____

History

Major Complaint _____

How Long Has Your Child Had This Condition? _____ Date Of Onset _____

Have They Had This Condition Before? ☐ Yes ☐ No If Yes, When? _____

Does Your Child Have A Family History Of This Condition? _____

What Have You Done For Your Child's Relief And Was It Of Benefit? _____

Has Your Child Had Previous Chiropractic Care? ☐ Yes ☐ No

Did They See A: ☐ Symptom Based Chiropractor (Focuses Only On Back And Neck Pain)

☐ Wellness Chiropractor (Focuses On Health And Well Being As The Underlying Cause Of Pain)

What Was The Reason For Your Child's Initial Visit? _____

Why Are You Changing Chiropractors? _____

Has Your Child Ever Been Hospitalized Or Had Any Surgeries? If Yes, For What And When? _____

_____

List All Medications / Nutritional Supplements Your Child Is Now Taking (Prescription & Non-Prescription): _____

_____

What Are Your Health Goals For Your Child? _____

How Do You Expect To Achieve These Goals?_____

Please Mark If Your Child Has Had Any Of These Symptoms In The Last Twelve Months:

- ☐Allergies
- ☐Anemia
- ☐Arthritis
- ☐Asthma
- ☐Bed Wetting
- ☐Blurred / Double Vision
- ☐Cancer
- ☐Chicken Pox
- ☐Colic
- ☐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
- ☐Kidney Problems
- ☐Liver Problems
- ☐Lower Back Pain / Stiffness
- ☐Measles
- ☐Mid Back Pain / Stiffness
- ☐Mood Swings
- ☐Mumps
- ☐Neck Pain / Stiffness
- ☐Numbness / Tingling (Arms / Fingers / Hands)
- ☐Numbness / Tingling (Buttocks / Legs / Feet / Toes)
- ☐Other Accidents / Falls
- ☐Painful Cough / Sneeze
- ☐PMS / Irregular Periods
- ☐Pneumonia
- ☐Polio
- ☐Rheumatic Fever
- ☐Ringing In Ears R L
- ☐Rubella
- ☐Shoulder Pain R L
- ☐Skin Problems
- ☐Sleep Problems
- ☐Stress
- ☐Stroke
- ☐TMJ / Jaw Pain
- ☐Tuberculosis
- ☐Ulcers
- ☐Upper Back Pain / Stiffness
- ☐Whooping Cough

This is to certify that my child is 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 child's 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 and your child 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 To Child

_____

Print Name Relationship To Child

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

_____ _____

Parent / Legal Guardian Authorizing Care Signature Authorized Provider Representative

_____ 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 my child. 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 child's 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 my child 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 child's care at this office, any outstanding charges for professional services rendered to my child 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 parent or responsible party with the power to execute this document and accept these terms.

Patient Name Date

Parent / Legal Guardian Authorizing Care 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 child's care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care for my child on this basis.

_____ _____
Patient Name Printed Date

_____ _____
Parent / Legal Guardian Authorizing Care Signature Authorized Provider Representative

