Welcome to Transformation Health! Our first step towards helping you move towards greater health and vitality is to find out more about you. Please fill out the following information regarding your health, your life and your overall well-being. Therapeutic massage 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, an assessment will thoroughly evaluate your need for massage. Our massage therapist will explain their recommendations and give you a complete action plan to optimize your health and to allow you to live life more fully!

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 and therapeutic massage 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

NEW MASSAGE 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

Major Complaint _____

How Long Have You Had This Condition? _____ Date Of Onset _____

Have You Lost Workdays? ☐ Yes ☐ No If Yes, How Many? _____

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

Was The Injury Accident Related? ☐ Yes ☐ No ☐ Auto ☐ Work If Yes, When? _____

When Was Your Most Recent Auto Accident? _____When Was The One Before That? _____

What Have You Done For Relief? _____

Have You Received Previous Massage Therapy? Yes ☐ No ☐

Did You See A: ☐ Symptom Based Massage Therapist (Focuses Only On Back And Neck Pain)

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

What Was The Reason For Your Initial Visit? _____

Why Are You Changing Massage Therapists? _____

Have You Ever Been Hospitalized Or Had Any Surgeries? If Yes, For What And When? _____

_____

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

_____

What Are Your Health Goals? _____

How Do You Expect To Achieve These Goals?_____

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 / Feet / Legs / 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

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.

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

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

I understand that therapeutic massage should not be construed as a substitute for medical examination, diagnosis, or treatment and I should see a chiropractor, physician or other qualified medical specialist for any mental or physical ailment of which I am aware. 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(s) should be construed as such. However, during the course of a massage session if we encounter 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.

Because massage is contraindicated (should not be performed) under certain medical conditions, I affirm that I have stated all of my known medical conditions and have answered all questions on this form and / or asked by my massage therapist honestly. I agree to keep this office updated in future sessions as to any changes in my medical profile. I also agree there shall be no liability on the practitioner's part should I fail to do so.

If I experience any pain or discomfort during the course of the session(s), I will immediately inform my massage therapist so that their pressure, strokes and / or technique may be adjusted to my level of comfort.

It is also understood that any illicit or sexually suggestive behavior, either physical or verbal, made by me, will result in immediate termination for the session and I will be liable for payment for the full scheduled appointment and I may be reported to the appropriate authorities.

We reserve the right to charge a fee of 50% of the scheduled base service amount to the form of payment that we have securely stored within your records on the day of the scheduled appointment if there is not a 24 hour notice given for a cancelled and/or no-show appointment.

For safety and liability reasons, we ask that you leave your child/ren at home during your massage session/s. If they are brought, we reserve the right to refuse the session and charge the full fee. Also, due to HIPAA regulations, we cannot allow third parties to wait for someone receiving a massage during closed, non-staffed office hours.

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

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

I therefore accept therapeutic massage on this basis.

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

_____

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

