



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. 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,

A handwritten signature in black ink, appearing to read 'Dr. C.J. Trupp III', written in a cursive style.

Dr. C.J. Trupp III

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

NEW 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? No Yes If Yes, How Many? _____

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

Was The Condition Accident Related? No Yes 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 Chiropractic Care? No Yes

Did You 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 Initial Visit? _____

Why Are You Changing Chiropractors? _____

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:

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

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
_____	_____
_____	_____

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

TTH Staff Initial Here

Copy Given To Patient

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