



*Dr. Darrell Volschke, DC*

*CACCP*

## **Welcome to Active Health Chiropractic**

Thank you for choosing our office. We are committed to providing you and your family with the highest quality of chiropractic care available so that you heal quickly and enjoy an active, healthy, long life. We will be working together to help you and your family reach your health and lifestyle goals.

If you ever have any questions about your chiropractic care, please don't hesitate to ask Sam, our highly educated chiropractic team member. All of your questions, even the ones you haven't even thought of yet, will be answered during your Chiropractic Report on your second visit.

Chiropractors have become the primary care doctors for millions of people around the world. Regardless of your reason for visiting our office today, our goal is to become your family's trusted provider and resource for living a healthy lifestyle throughout your lifetime.

*Active Health Chiropractic  
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**(Over)**



## Office Fee Schedule and Financial Policy

<u>Service</u>	<u>Fees</u>
Consultation with Dynamic Spinal Exam (does not include adjustment)	\$75
X-Rays	\$ Will be referred to Diagnostic Center
Adjustment	\$ 40
Re-Exam (does not include adjustment)	\$60

### Financial Policy and Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange an Active Life Plan in advance. These plans are designed to be the most cost effective way to keep you and your family as healthy as possible. They include your Crisis Care, Critical Transition and Lifestyle Care Options. Details of these plans will be discussed with you during your Chiropractic Report. Please choose one of the following documentation options:

- Insurance:** If you have insurance that covers chiropractic, we will give you all of the information you need to get reimbursed quickly. This includes your diagnosis, prognosis and copies of your records or reports. We have found it is easier for your record keeping, and ours, if we give you receipts at the end of your first visit and then once a month after that. Just send your receipts with a copy of your claim form to your insurance company, and they will communicate with you about your reimbursement. Remember your agreement with your insurance company is between you and them. Please note that many insurance policies may not reimburse for Critical Transition or Lifestyle Care.
- No Insurance:** If you do not have health insurance, choose not to use your health insurance or are participating in Lifestyle Care, you may request a receipt for tax purposes or a Health Savings Account (HSA) indicating the total amount you have paid for chiropractic care during the year. There is no insurance documentation given with these receipts.

If a special situation arises, such as an auto accident or a worker's compensation injury, a new examination will need to be performed and you will be charged our regular fees until the claim is settled. We will help you get reimbursed as quickly as possible on these claims.

As stated above, payment is due at the time services are rendered, unless an Active Life Plan is arranged in advance. Any unpaid balance will be submitted to an attorney/debt collection agency, which will affect your credit, and you will be responsible for all fees involved.

I, (Patient/Guardian) \_\_\_\_\_ have read and I understand the above policies. I have initialed the option that applies to me.

\_\_\_\_\_  
(Patient/Guardian Signature)

\_\_\_\_\_  
(Date)

## Personal and Family Health History

Name \_\_\_\_\_  
 Date \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_  
 E-mail \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ (Age \_\_\_\_\_)  
 Referred By \_\_\_\_\_

**Number of Siblings and Ages**

**Previous Chiropractic Care?**

Name _____	Age _____	Yes ___	No ___	Reason _____
Name _____	Age _____	Yes ___	No ___	Reason _____
Name _____	Age _____	Yes ___	No ___	Reason _____
Name _____	Age _____	Yes ___	No ___	Reason _____

You deserve to be healthy. When you were conceived, you were given the blue-prints, intelligence, and systems to live an active, healthy, long life. Unfortunately, the natural expression of your health can be interfered with. Through your examination and through your involvement in chiropractic care, we will work to remove these interferences and keep them out of your life, so that you can heal quickly and live the quality lifestyle you deserve.

	<b>Patient</b>	<b>Chiropractor's Comments</b>
<b>Circle all that Apply</b>		
<b>1. Was Your Birth Traumatic?</b>		
Long Delivery?	Y	_____
Difficult Delivery?	Y	_____
Forceps?	Y	_____
Caesarian?	Y	_____
Breach/cephalic?	Y	_____
Home birth?	Y	_____
Mother given drugs during delivery	Y	_____
Induced Labor?	Y	_____
<b>2. Growth and Development</b>		
Did you ever once...		
Learn to care for your spine?	Y	_____
Fall out of bed?	Y	_____
Bang your head?	Y	_____
Breastfeed?	Y	_____
Childhood sickness?	Y	_____
Have any Accidents?	Y	_____
Have Surgery?	Y	_____
Take Drugs?	Y	_____
Fall while learning to walk?	Y	_____
Bullied by your siblings?	Y	_____
Child abuse	Y	_____
Spanking?	Y	_____
Pulled ear/chin	Y	_____
Other	Y	_____
Chair pulled out when sitting?	Y	_____
Fall down the stairs?	Y	_____
Pulled by your arm?	Y	_____
Experience other traumas?	Y	_____
<b>3. Current Health Habits</b>		
Did/do you...		
Smoke?	Y	_____
Drink	Y	_____
Diet (do you eat healthy foods?)	Y	_____
Have you been in accidents?	Y	_____
Have you had surgery and organs replaced/removed?	Y	_____
Drugs? (Prescriptive or Non-Prescriptive)	Y	_____
Have Teeth Problems?	Y	_____
Have Eye Problems?	Y	_____
Have Hearing Problems?	Y	_____
Exercise regularly?	Y	_____

Have sleeping problems? (nightmares)? Y \_\_\_\_\_  
 Have occupational stress? Y \_\_\_\_\_  
 Have physical stress? Y \_\_\_\_\_  
 Have mental stress? Y \_\_\_\_\_  
 Have hobbies/sports injuries? Y \_\_\_\_\_  
 Sleeping posture – side–stomach–back \_\_\_\_\_

**Current Health Condition**

Present Complaint or Crisis? If no current crisis, what is the reason for your visit today?  
 Major \_\_\_\_\_  
 Pain or Problem started on \_\_\_\_\_  
 Pains are:  Sharp  Dull  Constant  Intermittent  
 What activities aggravate your condition/pain? \_\_\_\_\_  
 What activities lessen your condition/pain? \_\_\_\_\_  
 Is condition worse during certain times of the day? \_\_\_\_\_  
 Is this condition interfering with work? \_\_\_\_\_ Sleep? \_\_\_\_\_ Routine? \_\_\_\_\_ Other? \_\_\_\_\_  
 Is this condition getting progressively worse? \_\_\_\_\_  
 Other Doctors seen for this condition \_\_\_\_\_  
 Any home remedies? \_\_\_\_\_

**Other symptoms:**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Headaches         | <input type="checkbox"/> Pins & Needles in Legs    | <input type="checkbox"/> Depression         | <input type="checkbox"/> Feet Cold       |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Pins & Needles in Arms    | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Hands Cold      |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Fingers | <input type="checkbox"/> Loss of Memory     | <input type="checkbox"/> Stomach Upset   |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Numbness in Toes          | <input type="checkbox"/> Ears Ring          | <input type="checkbox"/> Constipation    |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Numbness in Breath        | <input type="checkbox"/> Fever              | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Shortness of Breath       | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Buzzing in Ear  |
| <input type="checkbox"/> Irritability      | <input type="checkbox"/> Fatigue                   | <input type="checkbox"/> Cold Sweats        |  |
| <input type="checkbox"/> Chest Pains       |  | <input type="checkbox"/> Loss of Smell      |  |
| <input type="checkbox"/> Dizziness         |  | <input type="checkbox"/> Loss of Taste      |  |
| <input type="checkbox"/> Face Flushed      |  | <input type="checkbox"/> Diarrhea           |  |
| <input type="checkbox"/> Neck Stiff        |  |   |  |

Have you been under drug and medical care? \_\_\_\_\_  
 What medications are you taking? \_\_\_\_\_  
 How Long? \_\_\_\_\_ Have you had surgery? \_\_\_\_\_ What? \_\_\_\_\_ When? \_\_\_\_\_  
 What side effects have you experienced from the drugs and surgery? \_\_\_\_\_  
 Supplements? \_\_\_\_\_

**Family History:**

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Your oldest grandparent on record lived to the age of \_\_\_\_\_.**  
 Still living  Deceased

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Active Life Plans are designed to get you feeling better quickly and to help you and your family be as healthy as possible. Please review the Active Life Plan Explanations prior to your Chiropractic Report so you can choose the level of participation that supports you in reaching all of your health goals.

**As a result of my chiropractic care, I would like to (Please check all that apply)**

- Feel better quickly
- Have a healthier spine and nervous system
- Live a healthier lifestyle

\_\_\_\_\_ Patient Signature \_\_\_\_\_ Date



## 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 able 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 spine.

**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, if during the course of a chiropractic spinal evaluation, 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  
(Patient/Guardian)  
statements.

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/Guardian Signature)

\_\_\_\_\_  
(Date)