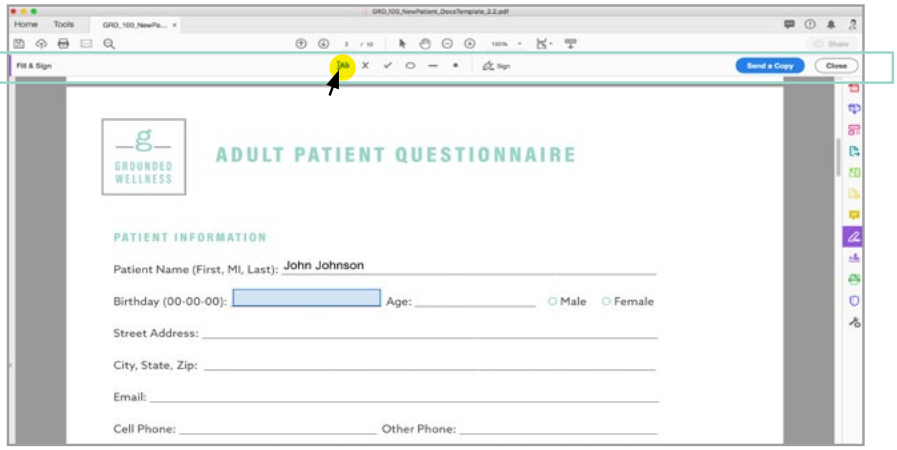
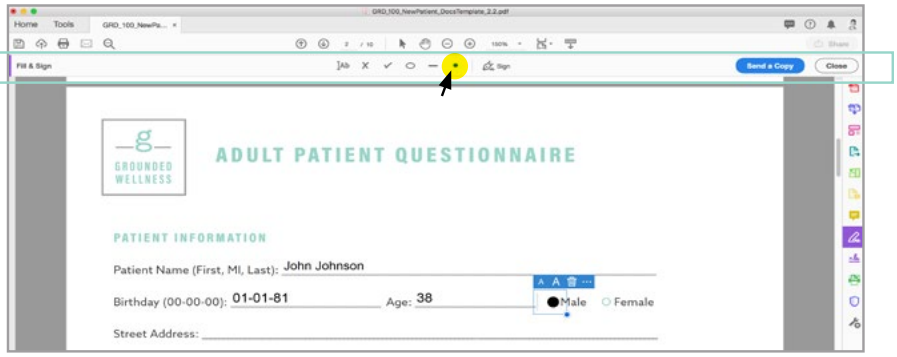
GROUNDED WELLNESS

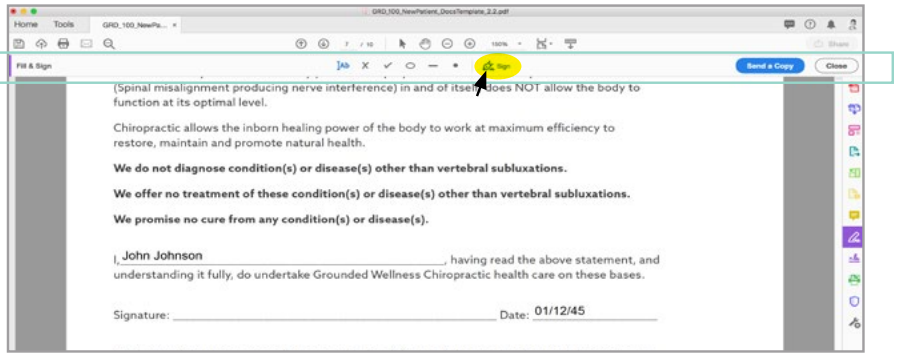
HOW TO DIGITALLY FILL OUT THESE FORMS IN ADOBE ACROBAT

To maximize your time in our office and reduce the amount of wait time, please fill out *all* the forms completely via Adobe Acrobat and email them back to us at:

hello@groundedwellness.co







1. Open file in Adobe Acrobat
2. Using the **Fill & Sign** tool simply click on the **Text Fill Tool** at the top tool bar.
3. Click into the document in an area that needs text. It should highlight and you can then type.
4. Use the **tab** button on your keyboard or your mouse to move to the next text box.
5. To **fill in a dot**, simply click on the dot, x or check box to make your choice.
6. To **sign a document** select the sign tool, create a signature or use an existing signature you have saved.

For more in depth instructions, there are several tutorials online you can visit.

GROUNDED WELLNESS

WHAT TO EXPECT AT GROUNDED WELLNESS

Your family's health is our passion. That's why we've created a holistic wellness chiropractic experience focused solely on families and the healthy lives they desire to live. **So you can truly have a partner and coach in your families wellness that will last a lifetime.**

Here's what you can expect from Grounded Wellness as a new client:

1. We discuss your families health and lifestyle goals.
2. You'd receive your first chiropractic evaluation and first adjustment.
3. Together, we create a whole-body health plan.

Once we begin your whole-body health plan through chiropractics and coaching you can expect to:

1. Feel taken care of and heard.
2. Experience positive and progressive care.
3. Leave each session inspired, hopeful and able to accomplish wellness needs for you / family.

GROUNDED WELLNESS

ADULT PATIENT QUESTIONNAIRE

PATIENT INFORMATION

Patient Name (First, MI, Last): _____

Birthday (00-00-00): _____ Age: _____ ○ Male ○ Female

Street Address: _____

City, State, Zip: _____

Email: _____

Cell Phone: _____ Other Phone: _____

Would you like text message reminders? Please select one:

- ○ Opt IN for text message appointment reminders
- ○ Opt OUT for text message appointment reminders

Spouse/ Partner's Name: _____

Cell Phone: _____ Email: _____

Would you like him/ her to be your emergency contact? ○ Yes ○ No

If no, please provide an emergency contact name and number:

Emergency Contact Name: _____

Cell Phone: _____ Email: _____

Primary Physician Name: _____ Phone: _____

How did you find out about our office?

GROUNDED WELLNESS

ADULT PATIENT QUESTIONNAIRE

CURRENT HEALTH CONDITIONS

What health condition(s) (if any) bring you in to be evaluated?

Are you here for preventative chiropractic, holistic wellness and nutrition? ○ Yes ○ No

When did the condition(s) first begin?

How did it start?	○ Gradually	○ Overtime	○ Suddenly
Severity?	○ Mild	○ Moderate	○ Severe
Frequency?	○ Constant	○ Frequent	○ Occasional
Problem Side?	○ Left	○ Right	○ Bilateral (both)

Pain Intensity (1-10), 10 being the worst: _____

Explain your type of pain: _____

○ Aching ○ Sharp ○ Shooting ○ Burning ○ Throbbing ○ Tingling

Numbness or tingling? ○ Yes ○ No If yes, please explain:

Does the pain radiate? ○ Yes ○ No If yes, please explain:

My pain is worse in the: ○ Morning ○ Afternoon ○ Evening ○ Night

Is the condition: ○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

What makes the condition better?

What makes the condition worse?

Have you ever received care for this condition before? ○ Yes ○ No If yes, please explain:

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ADULT PATIENT QUESTIONNAIRE (CONT.)

Any other concerns?

Please list any drugs/ medications/ vitamins/ other that you are taking:

Please list your hospitalization and surgical history to the best of your knowledge:

Please list any food intolerance or allergies you may have:

Do you know your blood type? (Please Share)_____

What do you find your body craving for food?

Please check any applicable pre-existing conditions:

○ Anemia ○ Arthritis ○ Asthma ○ Cancer ○ Diabetes ○ Epilepsy ○ Hearing Loss
○ Headaches ○ Joint Pain ○ Kidney Issues ○ Reflux/Ulcers ○ Seizures ○ Stroke

For Women: Are you currently pregnant? ○ Yes ○ No

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ADDITIONAL HISTORY

FAMILY HISTORY

Family Member	#	Back	Heart	Stroke	Cancer	Diabetes	High BP	Thyroid	Good Health
Mother	1								
Father	1								
Sister(s)									
Brother(s)									

ACTIVE & SOCIAL HISTORY

	Daily	3x/wk	2x/wk	1x/wk	2x/mo	1x/mo	Never
Standing & Moving							
Standing at Desk							
Sitting at Desk							
Work on a Computer							
Work on a Phone							
Moderate/ Heavy Labor							
Stay at Home							
Deliver Packages							
Retired							
Tobacco/ Smoke							
Vape							
Alcoholic Beverages							
Caffeine							
Exercise							
Generally Active							

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HEALTH & WOMENS HISTORY

Please highlight or circle all that apply:

Addiction	Colitis	Heart Disease/Attacks	Paralysis
Anemia	Constipation	Heart Murmur	Pneumonia
Arrhythmia	Depression/Anxiety	Hemorrhoids	Polio
Arthritis	Diabetes	Hepatitis	Prostate Problems
Asthma	Dizziness	High/Low Blood Pressure	Reflux/Ulcers
Blood Clots	Eating Disorder	High Cholesterol	Rheumatic Fever
Blurred Vision	Emphysema	HIV/AIDS	Seizures
Blood Disorder	Epilepsy	Joint/Back Pain	Sexual Dysfunction
Bowel Problems	Gall Bladder Disease	Kidney Infection	Sickle Cell
Broken Bones	Genital Herpes	Kidney Disease/Stones	Stroke
Cancer	Glaucoma	Liver Disease	Suicidal Thoughts
Cataracts	Gout	Mental Disorder	Thyroid Disease
Chickenpox	Hearing Loss	Migraines	Tuberculosis
Cold Sores	Headaches	Osteoporosis	Abnormal Urine

FOR WOMEN ONLY | LABOR & DELIVERY HISTORY

How many children do you have? _____ What are their ages? _____

Please select all that apply:

○ Natural vaginal birth ○ Scheduled C-section ○ Emergency C-Section ○ V-Back

Please select all that apply:

○ At home birth ○ At birthing center ○ At hospital ○ Other: _____

Doctor / Obstetrician's Name: _____

Please check any applicable interventions or complications to any of your pregnancies:

○ Breech ○ Induction ○ Epidural ○ Pain Meds ○ Episiotomy

○ Vacuum extraction ○ Forceps ○ Other_____

Please describe any other concerns or notable remarks about your labor and/or delivery experience:

ACKNOWLEDGMENT

Print Name: _____

Signature: _____ Date: _____

GROUNDED WELLNESS

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that both are seeking and working for the same goals.

Chiropractic does NOT diagnose or treat disease. Chiropractic has only three goals: to LOCATE, ANALYZE, and CORRECT spinal interference within the nervous system.

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (Spinal misalignment producing nerve interference) in and of itself, does NOT allow the body to function at its optimal level.

Chiropractic allows the inborn healing power of the body to work at maximum efficiency to restore, maintain and promote natural health.

We do not diagnose condition(s) or disease(s) other than vertebral subluxations.

We offer no treatment of these condition(s) or disease(s) other than vertebral subluxations.

We promise no cure from any condition(s) or disease(s).

I,_____, having read the above statement, and understanding it fully, do undertake Grounded Wellness Chiropractic health care on these bases.

Signature: _____ Date: _____

I understand that I am personally responsible for all fees and charges. I understand that payment is due at the time services are rendered. I understand that any third party payer may choose not to reimburse me for the cost of any health care procedure. I understand that if my third party payer chooses not to reimburse me for any reason, including but not limited to a deductible not being met, I am personally responsible for all fees and charges. I understand that a $25 charge will be applied to all returned checks. I understand that any reconciliation or adaptation of fees are at the discretion of the chiropractor and is to be kept confidential between the chiropractor and myself. I agree to receive important information regarding my chiropractic care via email, phone or mail. By signing I understand and agree to the above financial agreement.

Print Name: _____

Signature: _____ Date: _____

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AGREEMENT OF TREATMENT

At each visit, you will be evaluated to determine if an adjustment is warranted. If so, a spinal adjustment (S8990) and or an extra spinal adjustment (S8990) will be given.

I, _____, understand and agree to receive and participate in the above treatments.

Signature: _____

Date: _____

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HIPAA AGREEMENT

I have received and read the notice of privacy practices from Grounded Wellness | Chiropractic + Holistic Health

Print Name: _____

Signature: _____

Date: _____

GROUNDED WELLNESS

WELLNESS COACHING & MORE

We believe families deserve a partner in their holistic wellness journey—not a quick-fix or band-aid.

People they can trust and lean on for dependable chiropractic and wellness advice.

With that being said, we have many other great services / products that may fit your family's lifestyle needs.

Take a look and let us know if any of these services peak your interest. We'd be happy to chat with you about them.

- ○ Life Coaching
- ○ Supplements
- ○ Physical Therapy
- ○ Massage Therapy
- ○ Essential Oils
- ○ CBD Oil