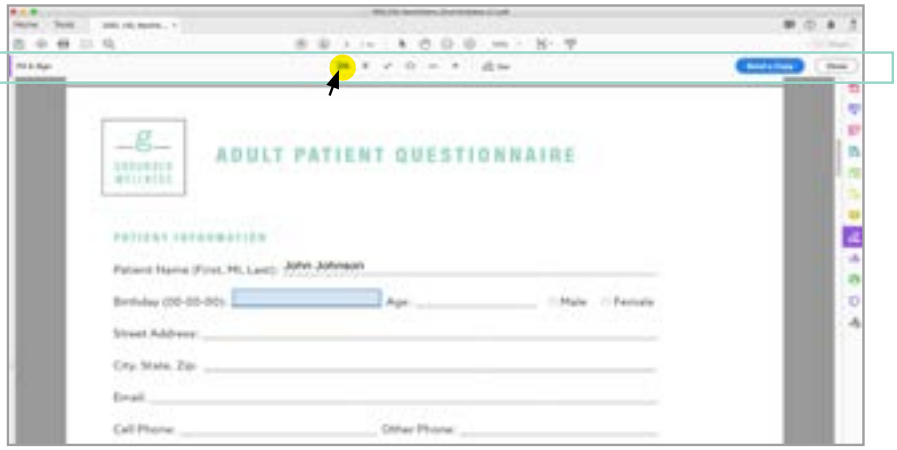
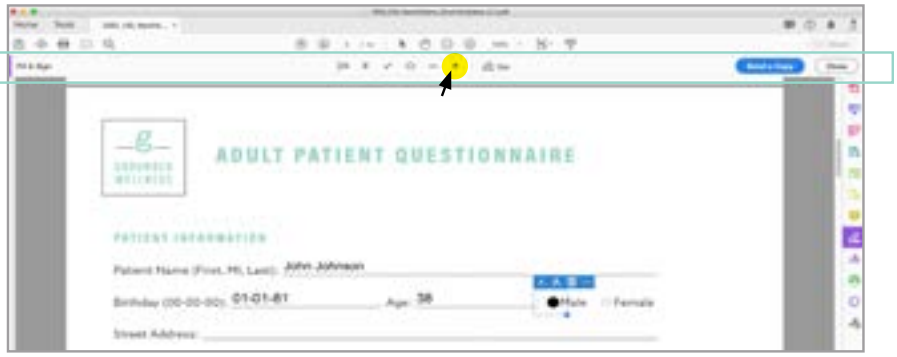
GROUNDED WELLNESS

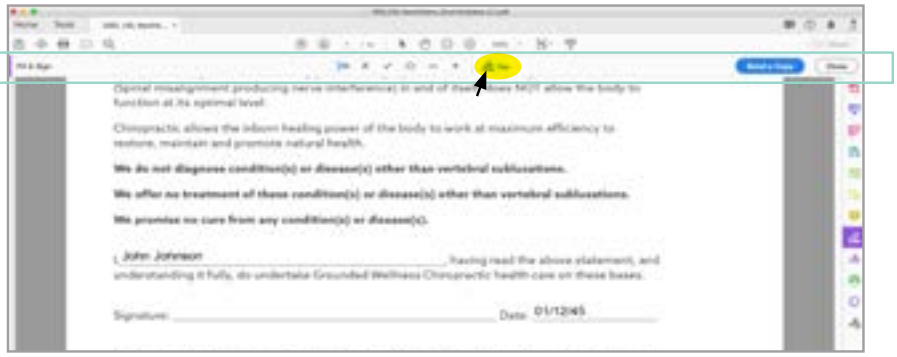
# HOW TO DIGITALLY FILL OUT THESE FORMS IN ADOBE ACROBAT

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.

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# PEDIATRIC PATIENT QUESTIONNAIRE

## PATIENT INFORMATION

Child's Name: _____

Parent/Guardian Name(s): _____

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

Street Address: _____

City, State, Zip: _____

Email: _____

Cell Phone: _____ Other Phone: _____

Cell Phone Carrier: ○ AT&T ○ Verizon ○ T- Mobile ○ Sprint ○ Other

**Would you like text message reminders? Please select one:**

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

How did you find out about our office? _____

## CURRENT HEALTH CONDITIONS

What health condition(s) bring your child to be evaluated?

When did the condition(s) first begin?

How did it start? ○ Suddenly ○ Gradually ○ Overtime

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

What makes the problem better?

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# PEDIATRIC PATIENT QUESTIONNAIRE

What makes the problem worse?

Has your child ever received care for this condition before? ○ Yes ○ No

If yes, please explain:

Please list any drugs/medications/vitamins/other that your child is taking:

Please list your child's hospitalization and surgical history:

Please list any food intolerance or allergies your child may have:

Please check any applicable pre-existing conditions:

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

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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: _____

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# 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: _____

**If patient is a minor:**

I authorize the doctors at Grounded Wellness | Chiropractic + Holistic Health to care for my child. I have read and understand the term of acceptance and agree to them.

Patient or Legal Guardian: _____

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# FAMILY HISTORY, DELIVERY & DEVELOPMENT HISTORY

| Family Member | # | Back | Heart | Stroke | Cancer | Diabetes | High BP | Thyroid | Good Health |
|---|---|---|---|---|---|---|---|---|---|
| Mother | x | | | | | | | | |
| Father | x | | | | | | | | |
| Sister | | | | | | | | | |
| Brother | | | | | | | | | |

## LABOR & DELIVERY HISTORY

Child's birth was: ○ Natural vaginal birth ○ Scheduled C-section ○ Emergency C-Section

Child's birth was: ○ At home ○ At birthing center ○ At hospital ○ Other: _____

Doctor/ Obstetrician's Name: _____

Please check any applicable interventions or complications:

○ Breech ○ Induction ○ Epidural ○ Pain Meds ○ Episiotomy

○ Vacuum extraction ○ Forceps ○ Other_____

Please describe any other concerns or notable remarks about your child's labor and/or delivery:

## GROWTH & DEVELOPMENT INFORMATION

Is/was your child breastfed? ○ Yes ○ No How long?_____

Any difficulty? ○ Yes ○ No If yes, please explain: _____

Did he/she ever use formula? ○ Yes ○ No How long?_____ _

Did/does your child frequently arch their neck/back, feel stiff or bang their head? ○ Yes ○ No

If yes, please explain:

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# FAMILY HISTORY, DELIVERY & DEVELOPMENT HISTORY (CONT.)

Have you chosen to vaccinate your child?

○ Yes, on a delayed or selective schedule ○ Yes, on schedule ○ No

If yes, please list any vaccination reactions:

Has your child received any antibiotics? ○ Yes ○ No If yes, how many times and list reason:

Night terrors or difficulty sleeping? ○ Yes ○ No If yes, please explain:

Behavioral, social, or emotional issues? ○ Yes ○ No If yes, please explain:

How many hours per day does your child typically spend watching TV, computer, tablet or phone?

○< hour ○2-3 hours ○5+ hours

How would you describe your child's diet? (Heavy in dairy? Wheat? Sweets? Juices?)

○ Fresh (Completely Organic) ○ Mostly Organic ○ Balanced (Some organic, fresh & processed)

○ Busy (Eating out, processed and some fresh & frozen) ○ Other: _____

## ACKNOWLEDGMENT & CONSENT

Print Name: _____

Signature: _____ Date: _____