Olena Wellness Center
7856 Westside Park Drive, Suite H
Mobile, AL 36695
(251) 300-1335
olenawellness.com
olenawellness@gmail.com
Gaie Feuerstein DC Brian R. Smith DC

Olena Wellness Center office is located at **7856 Westside Park Drive, Suite H.** The Suite letters are over the doors and our sign is on the door. The office park is called Veterans Memorial Parkway Center. It is located on Schillinger Road about 1 mile south of the Cottage Hill and Schillinger intersection.

The office cell phone is (251) 300-1335 and it also accepts texts. **Please give 48 hours' notice if you need to reschedule. Others are waiting to be seen by the doctor.**

Attached are the new patient forms for you to print, fill out and bring with you if possible. We will go over the information during the appointment.

You should wear loose, comfortable clothing; we do not use gowns. PLEASE DO NOT WEAR PERFUME, HAIRSPRAY OR SCENTED DEODORANT OR OTHER BODY PRODUCTS. MOST OF OUR STAFF AND MANY OF OUR PATIENTS ARE SENSITIVE TO CHEMICAL ODORS AND THESE PRODUCTS MIGHT MAKE THEM SICK!

Please bring any medications and any supplements taken regularly with you - the actual pills in their bottles, not just a list.

If you have lab tests done within the last two years, please bring them with you.

We look forward to working with you!

Sincerely,

Dr. Brian R. Smith DC
Dr. Gaie Feuerstein DC

First Time Evaluation (Child)

Today's date: _____ Referred by? _____
Child's Name: _____ Birth date: ____/____/___ Age: ____
Parents/Guardian Name: _____
Mailing address: _____
Phone (receives texts) _____ Other Phone: _____
Emergency Contact: _____

* * * * * * * * * * * *

I hereby give permission for _____ to be treated at Olena Wellness. _____ _____
(child's name)
(Parent/Guardian signature) (date)

Symptoms/Concerns: Please list current concerns. The doctor will ask for details during the exam.
_____
_____

Allergies to medication, herbs, foods, environmental: _____
_____

History of severe colic, ear infections, other infections, eczema, asthma, learning difficulties, depression, anxiety, mood disorders or other problems (circle)
Comments: _____

Other Information: Please tell us any additional information about your/the child's health
_____
_____

Diseases: Please list all past and present diagnosed medical conditions _____
_____

Medications (including over the counter) Please list medications currently taken regularly
_____ _____
_____ _____

Surgeries and Major Injuries Are pins, plates or screws still present?
_____ _____
_____ _____

Dental work (circle) Braces, Fillings, Crowns, Root Canals, Wisdom teeth or other teeth pulled, Oral Surgery, Other _____

Is further dental work needed or ongoing?_____

Family History

Do you have any genetic information or concerns? _____

Relation	Grand Parents	Uncles / Aunts	Father	Mother	Siblings	Nieces / Nephews
Addiction/ Alcoholism						
Allergies						
Auto-Immune						
Blood Vessel Disease						
Cancer						
Diabetes/ Pancreas Disease						
Gut Disease						
Heart Disease						
Infertility PCOS						
Kidney Disease						
Learning Disability						
Lung Disease						
Mental Disorder						
Vaccine Reaction						

Other diseases: _____

Health Overview

(For the following questions, answer and circle the phrases which apply)

Exercise: What kind of exercise do you/does child do? Outside play? _____
Sports? _____

Sunlight Amount of natural sunlight received daily outside? _____

Sleep (**circle)** restful, restless, hard to get to sleep, wake up often, bad dreams,
other_____

Digestion: (circle) heartburn, reflux, burp often, bloating, pain after eating, nausea
other_____

Bowels (circle) 1 to 3 times daily, diarrhea, constipation: how often do you/does child go?_____
_____
Consistency: normal, too hard, very soft, diarrhea **Color:** brown black whitish **Other:** lots of mucus
lots of gas foul smell pellets other_____

Urination any history of infections or other problems? _____

Vaccinations: (circle) usual childhood shots, unvaccinated, are parents heavily vaccinated for military, mission work, other? _____

Has child received Gardisil? _____

Flu shots: no, annually, limited, comments _____
_____

Covid-19: no, yes, if yes, approximate date/s and brand if known (Pfizer, Moderna, J&J, other) _____

Has child ever had or suspected a reaction to a vaccine? _____

Describe: _____

Have you ever reported a vaccine injury to VAERS? _____

Electromagnetic Exposure: How many hours daily: Working on a computer/ laptop/Wi-Fi _____
Talking on a cell phone or Bluetooth ____ Wearing a Apple Watch, Sleep with electric blanket or near clock or cell phone _____ Live near high power lines, step-down transformer _____

Personal Products Exposed to: Fluoride or whitener toothpaste _____ Aluminum deodorant _____
Nail polish/acrylic/remover ____
Bug/flea spray _____ Weedkiller _____ Yard, household or school chemicals _____
Do you have Pets ? _____ Are they wormed regularly? _____ ___

Ever been sick during or after foreign travel?_____
_____

Have you ever suspected or been diagnosed with mold, yeast or fungal illness? _____
_____

Vitality Do feel you are: Too fatigued mentally or physically? _____ Losing strength / stamina? _____
Gaining or losing weight? _____ Lack of motivation or focus? _____

Girls only: Are you currently using (circle) any kind of hormones (the pill) for regulating period? Have you used these in the past?_____ How long? _____ Any hormonal problems such as acne, weight gain, depression, anxiety, abnormal bleeding? _____

Menstrual cycle: #days of menstrual flow _____ Length of menstrual cycle (28 days or other?) _____
Age you started? _____ Circle any of the following symptoms associated with your period: cramping bloating weakness mood swings cravings heavy bleeding back pain headaches
Other menstrual complaints? _____
_____
_____

Food Habits

Do you eat out at restaurants? _____ If yes, where usually? _____
_____ How many times per week? _____

Meal habits: Do you (circle) skip meals often irregular eating times eat past 7 PM

Water: Do you drink (circle): tap water purified water type of filter? _____

Processed foods: frozen dinners bottled or frozen juices processed breakfast foods chips

Meat: game beef pork lamb chicken turkey fish canned lunch meat

Oils: Canola Oil Vegetable Oil Crisco Fried Restaurant Foods Bottled Salad Dressings

Fruit and vegetables organic local garden commercial from store fresh frozen canned

Grains and beans: gluten-free no-grains no-beans organic commercially grown canned

Eggs/Butter: raw organic commercially bought margarine egg-beaters

Milk/cheese: raw organic low/non-fat Creamer or Cool Whip goat non-dairy

Food Stressors Circle and indicate how many times per week you consume the following types of foods:
Caffeine: Energy Drinks Coffee Decaf CocaCola/ Mountain Dew/ soda with caffeine Black tea Green Tea Pain meds with caffeine ie Excedrin _____
Artificial Sweeteners (in packets, drinks or food): NutraSweet Equal Splenda Truvia Stevia Monk Fruit Xylitol/Erythritol THM Sweetener _____ _____

Sugar/ Corn syrup: _____ Desserts, candy _____ Sweet Tea or Soda _____
Gatorade Energy Drinks Other _____

Highly Processed Foods: Chips / Crackers / Rice Cakes / Breakfast Cereals / Puffs / _____

Do you avoid any types of food such as gluten, dairy or meat, pork?
_____
Why?_____

Typical Diet:

Breakfast: _____
_____
Lunch: _____
_____
Dinner: _____
_____
Snacks: _____
_____
List any nutritional supplements you take regularly: _____
_____
_____

Do you want to gain or lose weight? _____ If so, how much? _____

What are your specific health goals? (What do you really want?)
_____
_____
_____

How strongly are you willing to commit to achieving your health goals (Please be honest!)
___ don't really want to change much
___ willing to change some
___ willing to change a reasonable amount
___ willing to do whatever it takes

How much confidence do you have in medical drugs (1=low, 10=high) _____

How much confidence do you have in your body's ability to heal if given the right nutrients and natural therapies (1=low, 10=high) _____

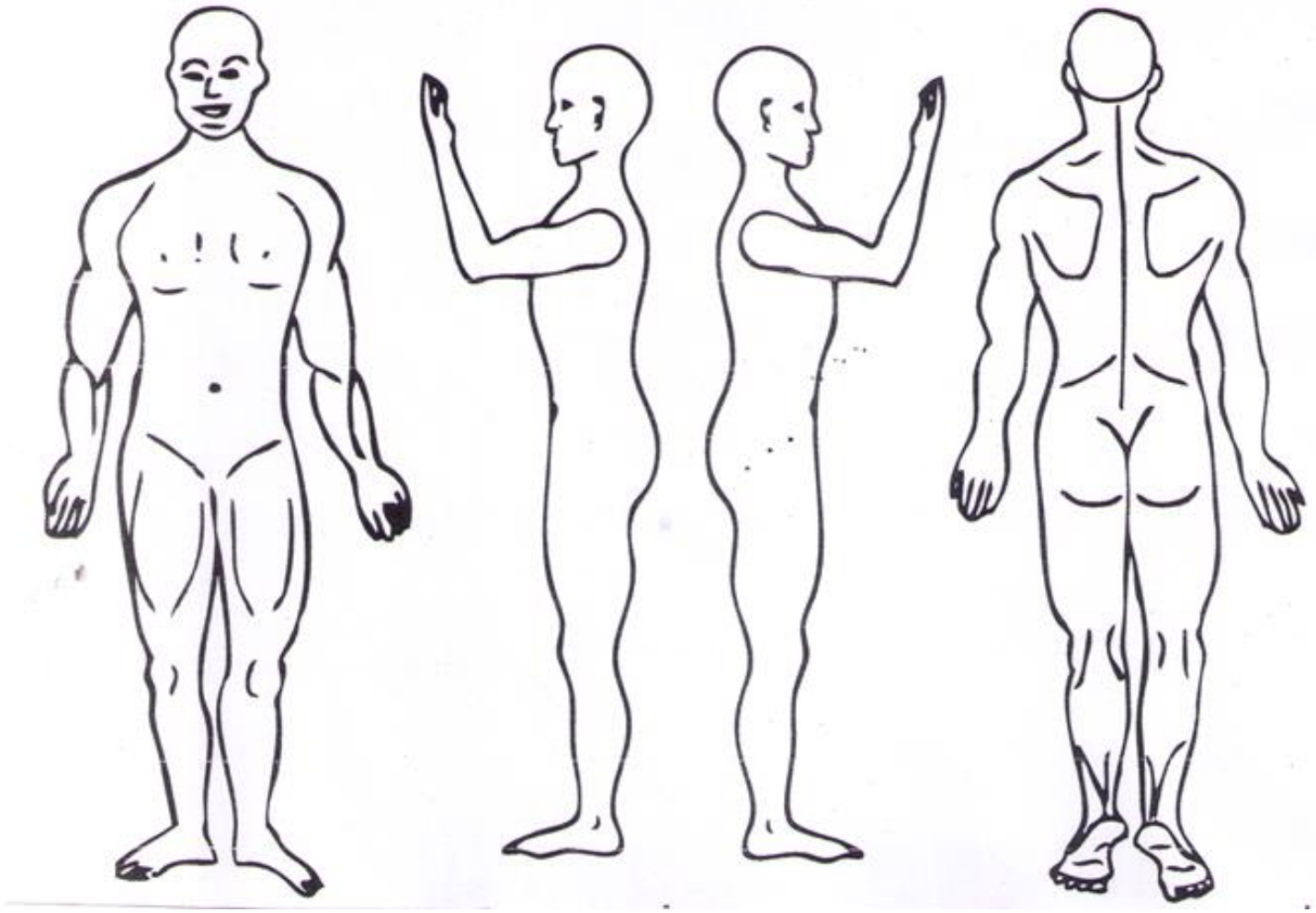
Leave this blank:

Pregnancy, Labor & Delivery, Neo-Natal Events: _____
_____
_____
_____
_____
_____
_____

INJURY & SCAR CHART
(not pain! Just injuries and scars)

Name: _____

Date: _____



Front Left Side Right Side Back

Draw Scars and other injuries (highlighting the area of injury). Include all injuries from Day 1 of life! Injuries can include stitches, broken bones, fractures, sprains, surgeries (major or minor), mole or cyst removals, bad falls especially to the back or tailbone, punches and hard blows especially to the face or head, poisonous bites, infections, piercings, tattoos, and vaccinations.

PAIN DRAWING

Highlight any current pain today, or areas that chronically hurt, even if it comes and goes