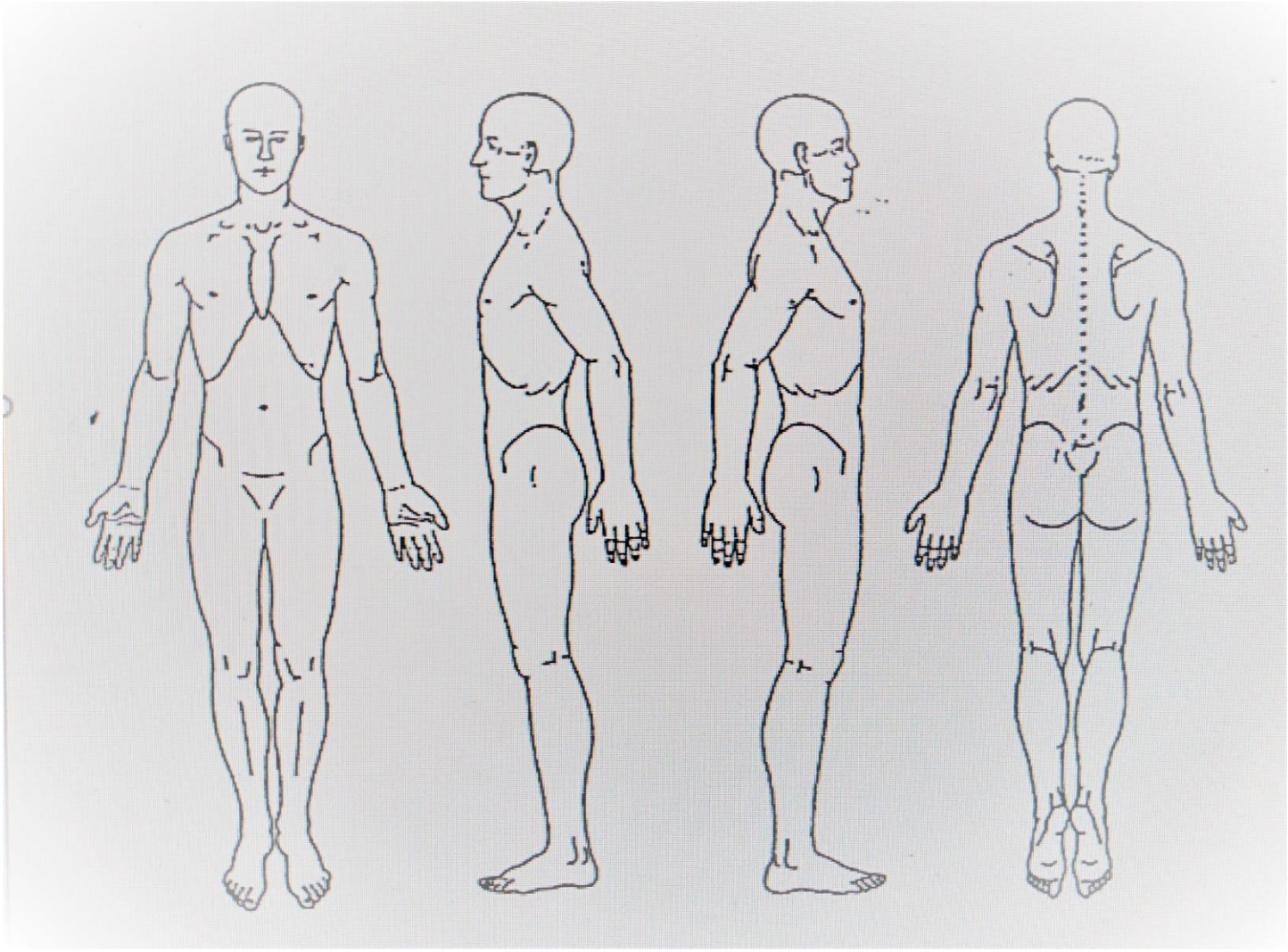
Your name: _____
Today's date: _____

PAIN CHART

Highlight location of pains, where it hurts now, and any chronic pain areas.



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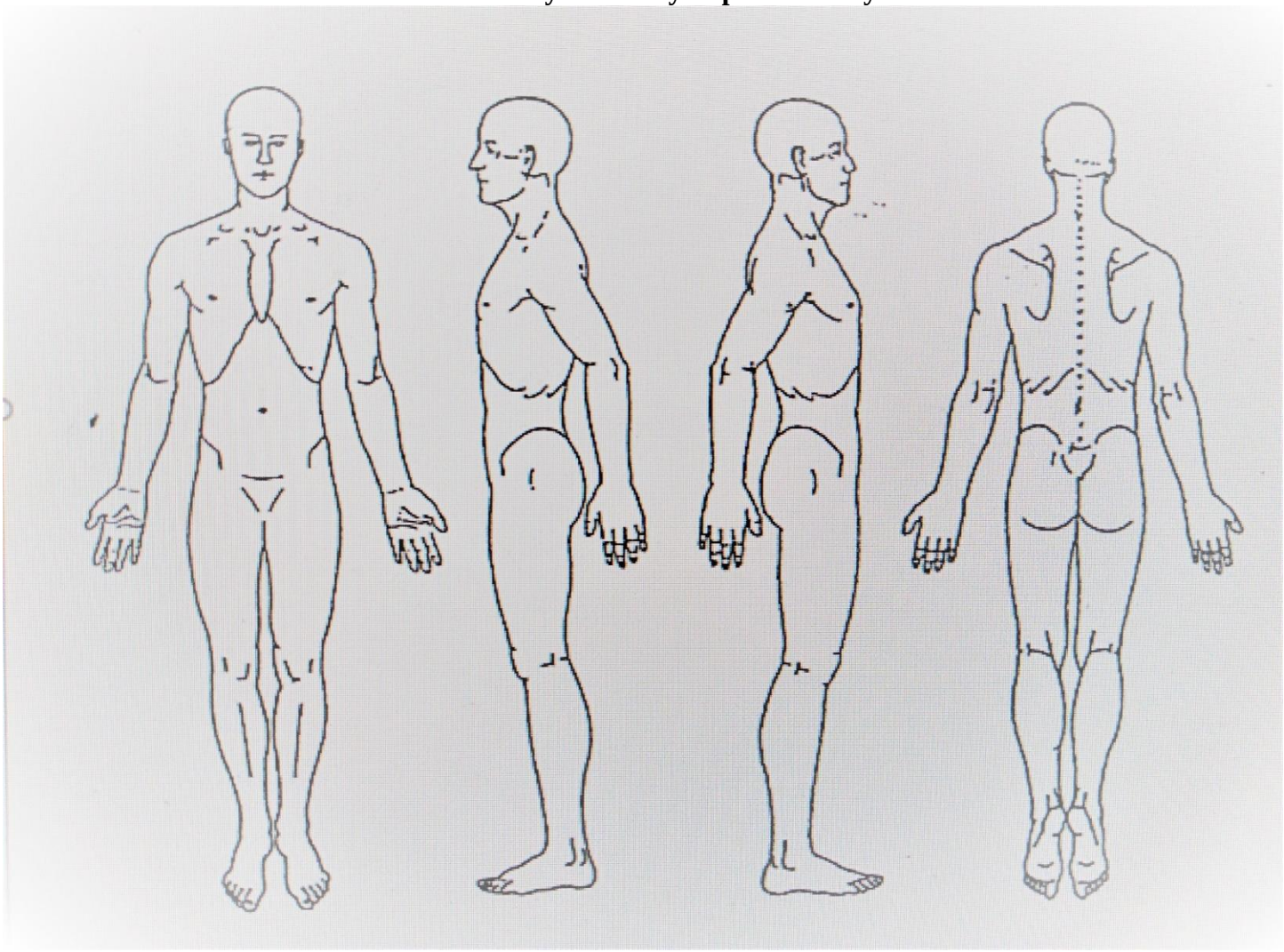
Your name: _____
Today's date: _____

PAST INJURIES AND SCARS

Please fill this out carefully! It is very important for your treatment.



Draw (use marker if you can) all injuries you can remember from Day 1 of life!

- Cuts and stitches
- Fractures
- Sprains
- Surgery scars whether major or minor
- C-sections and episiotomies, epidurals, lumbar blocks
- Cancer, mole or cysts removed
- Bad falls especially to the back or tailbone
- Blows to the face or head, concussions, teeth knocked out, nose injuries
- Poisonous bites, infections,
- Piercings, tattoos

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Olena Wellness

Adult Health History Questionnaire

Name:	**Birthdate: / /**	**□ M □ F**
Occupation:	**Marital Status: □ Single □ Married □ Divorced □ Widowed**	
Mailing Address:		
Phone:	**receives texts? □ yes □ no email:**	
Emergency Contact:	**Relationship:**	**Phone:**
Physician:	**Referred by:**	

Please list your current concerns and symptoms. The doctor will ask for details during the exam
_____
_____

List any past and present medical conditions that other doctors have diagnosed:
_____
_____
_____

Surgeries and Hospitalizations:	
Year	**Reason**
Are any plates, pins or screws still present? □Yes □ No If so, where?	
Have you ever had a blood transfusion? When?	

List your current drugs, both prescribed and over-the-counter, such as inhalers and pain pills			
Name of drug	**Reason prescribed**	**Strength**	**Frequency taken**

Allergies to any medications, vaccines, foods, herbs or environmentals such as pollens or chemicals?		
Name	**Reaction you had**	**When?**

In the past, have you taken any steroids or antibiotics or Z-Packs? Approximately when?
_____
_____

Vaccinations:
□ None □ Usual childhood shots □ Flu □ Shingles □ Pneumonia □ Tetanus □ Covid-19 □ C-19 Booster/s Did you have Covid-19? □ Not sure □ Yes □ No When? _____ Any Covid-19 or vaccine-related concerns? □Yes □ No If yes, describe:_____ _____

Mental Health – check all that apply
□ Major stress □ Anxiety □ Depression □ Inability to focus □ Obsessive thoughts □ Suicidal thoughts

Vitality - Do you feel you are:			
Too fatigued mentally or physically?	□ Yes □ No	Losing strength / stamina?	□ Yes □ No
Less interested in sex?	□ Yes □ No	Gaining weight?	□ Yes □ No
Lacking motivation?	□ Yes □ No	Having mood problems such as depression, anxiety, irritability?	□ Yes □ No

Please tell us any additional information about your health:
_____
_____
_____

Dental History		
Braces	□Yes □ No	
Accident/Injury?	□Yes □ No	
Fillings	□Yes □ No	□ Mercury amalgam (silver) □ Composite (white)
Crowns/Caps/Inlays	□Yes □ No	
Wisdom teeth extracted	□Yes □ No	At what age?
Other extractions	□Yes □ No	At what age?
Other oral surgery	□Yes □ No	At what age?
Dentures/Partials	□Yes □ No	
Brand of toothpaste used?		
Do you need further dental work?	□Yes □ No	

Men Only		
Have you had a PSA test? □Yes □ No	If yes, when?	Results:
Have you had a colonoscopy? □Yes □ No	If yes, when?	Results:
# of times you wake up to urinate at night _____		

Women Only		
Date of last menstruation	Do you have fertility issues? □Yes □ No	
Number of pregnancies	Number of live births	
Are you pregnant? □Yes □ No If yes, how far along?	Are you breastfeeding? □Yes □ No If yes, age of baby?	
Are you currently using: □ Birth control pills □ IUD □ Depo shot □ Hormone therapy	Do you have menstrual: □ Cramps □ Bloating □ Headaches □ Heavy bleeding/clotting □ Mood swings □ Irregular cycles	
Have you had a mammogram? □Yes □ No	If yes, when?	Results:
Have you had a thermogram? □Yes □ No	If yes, when?	Results:
Have you had a bone density test? □Yes □ No	If yes, when?	Results:
Have you had a colonoscopy? □Yes □ No	If yes, when?	Results:
Do you have any menopause issues such as: □ Hot flashes □ Weight gain □ Poor sleep □ Mood swings □ Brain fog □ Vaginal dryness □ Other		

Health habits and Personal Safety – check all that apply	
Exercise	□ None □ Mild (climb stairs, walk 3 blocks, golf) □ Occasional vigorous (less than 4xweek, 30 minutes) □ Vigorous 4xweek or more □ Sports (kind?)
Alcohol	□ None □ drinks per week □ Binge drinking, how often?
Tobacco	□ None □ Cigarettes /day □ Chew /day □ Other
Vape	□ Nicotine □ Non- Nicotine □ Daily, # times □ Occasional □ Previous use
Drugs	□ Kratom □ Gabatrol □ Recreational □ via needle injection □ Current use □ Previous use
Sunlight	Amount of natural sunlight received daily outside:
Sleep	□ restful □ restless □ hard to get to sleep □ wake up often □ bad or vivid dreams #hours of sleep per night □ other

Family Health History			
	Significant health problems		Significant Health Problems
Grandfather		Siblings: □ M □ F	
Grandmother		□ M □ F	
Father		□ M □ F	
Mother		Children: □ M □ F	
Siblings: □ M □ F		□ M □ F	
□ M □ F		□ M □ F	

Personal Lifestyle – check all that apply
□ Fluoride toothpaste □ Aluminum-containing deodorant □ Anti-aging skin cream □ Dark hair dye □ Nail polish/acrylic/remover □ Bug/flea spray □ Weedkiller □ Scented laundry soap and dryer sheets □ Fragrance plug-ins for house □ Scented candles □ Scented body wash and shampoos
Describe any workplace chemical exposure:
Have you ever suspected exposure or been diagnosed with mold, yeast or fungal illness? □Yes □ No
Do you have pets or livestock? □Yes □ No What kind?
Have you ever been sick during or after foreign travel?

Digestion – check all that apply
Stomach and Intestines: □ heartburn □ reflux □ burp often □ bloating □ pain after eating □ nausea □ vomiting □ Poor appetite □ other
Bowels: □ Diarrhea □ Constipation □ Gas (excessive) How often do you go?
Color: □ Brown □ Black □ Pale, chalk
Consistency: □ Normal □ Soft, unformed □ Hard, pebble-like □ Watery □ Foul smelling

Food Habits

Do you eat out at restaurants? □Yes □ No If yes, where usually? _____
How many times per week? _____

Water: Do you drink: □ tap □ purified □Alkaline other _____ filter type? _____

Processed foods: □ bottled or frozen juices □ cereal □ granola bars □ chips □ crackers □ pastries

Meat: □ game □ beef □ pork □ chicken □ turkey □ fish □ canned □ lunch meat □ imitation or lab-grown

Oils and fats: avocado □ coconut □ olive □ canola □ vegetable □ Crisco □ fried restaurant foods
□ bottled salad dressings and mayonnaise □ lard □ tallow □ butter □ margarine

Fruit and vegetables: □ organic □ local garden □ supermarket □ frozen □ canned □ none

Grains and beans: □ regular bread □ gluten-free □ no grains □ no beans □ organic □ commercially grown

Eggs: □ organic □ supermarket □ local yard eggs □ egg-beaters □ whites-only

Milk, Dairy: □ raw □ organic □ goat □ low-fat, non-fat □ coffee creamer □ Cool Whip
□ non-dairy (□ almond □ soy □ coconut) □ yogurt

Food Stressors – how many times per week do you consume:
Caffeine: _____Energy Drinks ____Coffee ____Decaf ____Soda with caffeine ____Black tea _____ Green Tea ____Pain meds with caffeine (i.e. Excedrin)
Artificial Sweeteners (in packets, drinks or food): ____NutraSweet, Equal/Splenda, Saccharin ____ Truvia/Stevia/Monk Fruit ____Xylitol/Erythritol/THM Sweetener
Sugar and Corn Syrup: ____desserts, candy ____sweet tea or soda ____Gatorade ____yogurt ____juice drinks ____ketchup and sweet pickles

Do you avoid: ____meat ____pork ____dairy ____wheat ____egg ____peanuts _____shellfish
____other _____Why?_____

Typical Diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

List any nutritional supplements you take regularly: _____

_____

_____

Do you want to lose weight? □**Yes** □ **No** 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) _____