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 for Infant&Toddler

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
(child's name)
Wellness. _____ _____
(Parent/Guardian signature) (date)

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

Allergies to medication, foods, other: _____
_____

History of colic, ear infections, other infections, antibiotics, steroids, eczema, asthma?(circle)
Comments: _____

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

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

Surgeries, Major Injuries
_____ _____
_____ _____

Any dental issues? _____

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

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)

Sleep difficulties? _____

Digestion: (circle) reflux, vomiting, bloating, constipation, diarrhea, _____
_____

Stool Consistency (circle): normal, too hard painful very soft, diarrhea **Color:** brown black whitish greenish 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? _____

Flu shots: no yes comments _____

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

Describe: _____

Have you ever reported a vaccine injury to VAERS? _____

Electromagnetic Exposure: Sleep near wifi router? Live near electric or cell towers or step-down transformer to your knowledge? _____

Personal Products Exposed to: Indoor air pollution, Glade Plug-Ins, Scentsy Candles, Dryer Sheets?
Bug/flea spray _____ Weedkiller _____ Monthly pesticide treatments or similar? _____
Do you have Pets ? _____ Are they wormed regularly? _____

Has child been exposed to mold or had chronic thrush or yeast infections? _____

Any Developmental issues, speech delay, clumsiness? _____
_____
_____

Food Habits

Picky eater? _____

Does child eat fast food? (Chick Fil e, MacDonalds etc) _____
_____ How many times per week? _____

Water: Does family use (circle): tap water purified water type of filter? _____

Processed foods: bottled juice processed breakfast foods chips crackers cookies
Canned fruit protein or granola bars hot dogs lunch meat chicken nuggets popsicles

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

Oils: Canola Oil Vegetable Oil Crisco Fried Restaurant Foods French Fries

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 none

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

Sugar/ Corn syrup: Desserts candy Sweet Tea or Soda KoolAid Bottled Juice
Gatorade Gummy vitamins or probiotics

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

Typical Diet:

Breakfast: _____
_____
Lunch: _____
_____
Dinner: _____
_____
Snacks: _____
_____

List any nutritional supplements taken regularly: _____
_____
_____

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

How strongly are you willing to commit to achieving these 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
___ want to change but feel overwhelmed

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

How much confidence do you have in the 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: _____
_____
_____
_____
_____
_____
_____