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 24 hours' notice if you need to reschedule. Others may be waiting to be seen by the doctor.**

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

You should wear loose, comfortable clothing as the appointment includes hands-on treatment as well as history, exam and consultation. The fee also includes follow up by email or phone, so please take advantage of it! Follow up is important for long term success.

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

We look forward to working with you!

Sincerely,

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

First Time Evaluation (Adult)

Please complete the following questions carefully. This information will help us to build a treatment plan and health-building program specifically designed for you.

Today's date: _____ Referred by? _____
Name: _____ Birth date: ____/____/___ Age: ____
Marital Status: S __ M __ D__ W __ No. of children_____ Height_____ Weight____
Occupation: _____ Hand Rt. ___ Lf. ____
Mailing address: _____
E-Mail:_____ Day Phone: _____ Eve Phone: _____
Emergency Contact: _____

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

Complaints Please list your current complaints and rate their severity on a scale of 1 to 10, 10 being the most severe. **(A pain drawing is provided at the end of this form).** The doctor will note the details during your history and examination.

_____
_____
_____
_____
_____

Other Information Please tell us any additional information or concerns about your health)

_____
_____
_____

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

Medications (including over the counter) Please list any medications you are taking and for how long

_____ _____
_____ _____
_____ _____

Surgeries and Injuries What injuries or operations have you had, at approximately what age? Any pins, plates, screws present? **(A Scar and Injury drawing is provided at the end of this form)**

_____ _____
_____ _____
_____ _____

Dental work (circle) Braces, Fillings, Crowns, Root Canals, Extractions, Dentures, Oral Surgery, TMJ, Other _____

Do you use Commercial Toothpaste? _____ If so, which brand _____

Do you need further dental work?

_____

Health Overview (For the following questions, answer and/or circle the phrases which apply to you)

Do/did/ you smoke or vape? _____ Amount _____ How long/since? _____
Recreational drugs? (strictly confidential) _____

Exercise What kind of exercise do you do? _____
How often? _____ For how long a time _____

Sunlight Amount of natural sunlight received daily outside? _____

Sleep How is your sleep? **circle:** restful, restless, hard to get to sleep, wake up often, bad dreams, other_____

Digestion How is your digestion? **circle**: adequate, poor, acid reflux, burp often, bloating, burning pain in stomach, other_____

Bowels How are your bowel eliminations? **Circle:** More than 3 times daily, once per day, skip days?
_____
Consistency: normal, too hard, very soft, diarrhea **Color:** brown black whitish **Other:** lots of mucus lots of gas foul smell pellets other_____

Urination How are your daily urinations? (**circle)** every 2-3 hours too frequent sense of urgency burning too small amount incontinence up at night # ___of times other_____
Vaccinations/Flu shots?_____
_____

Electromagnetic Exposure How many hours daily: Working on a computer/ laptop/Wi-Fi _____
Talking on a cell phone or Bluetooth ____ Wearing a wrist watch, FitBit or hearing aid (with battery) ____
In a vehicle _____ Near high power lines, step-down transformers, large electrical equipment _____
Sleep close to electric clock / electric blanket ____
Personal Products Do you regularly use: Fluoride toothpaste _____ Aluminum deodorant ____
Anti-Aging Skin Moisturizer ____ Nail polish/acrylic/remover ____ Dark hair dye ____
Bug/flea spray _____ Weedkiller _____ Yard, household or workplace chemicals _____
Pets ? _____ Are they wormed regularly? _____

Have you ever been sick after foreign travel?_____
_____

Vitality Do feel you are: Too fatigued mentally or physically? ___ Losing strength / stamina? _____
Disinterested in sex? _____ Having mood problems such as depression, anxiety, irritability? _____
Gaining weight? _____ Lack of motivation? _____

Women only: Are you pregnant? ____ Are you breast feeding? ___ Are you currently using (circle) hormones (topical cream, pills or implanted pellets, Depo shot, the Pill or have an IUD? Have you used any of these in the past?_____ How long? _____ Any hormonal problems such as acne, weight gain, depression, anxiety, abnormal bleeding etc _____
Any fertility issues? _____
Are you going through menopause? ____ Any problems? _____
Had a hysterectomy tubal ligation ablation laparoscopy other surgery? _____
If so when? _____ Why_____

Menstrual cycle: #days of menstrual flow _____ Length of menstrual cycle (28 days or other?) _____
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: a) raw b) organic c) low/non-fat d) non-dairy 'creamer' or Cool Whip f) soy

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 _____
Sugar/ Corn syrup: Alcohol _____ Desserts, candy _____ Sweet Tea or Soda _____
Highly Processed Foods: Chips / Crackers / Rice Cakes / Breakfast Cereals / Puffs / _____
Do you avoid: wheat corn soy oats egg peanuts shellfish citrus beans raw foods other?_____

Typical Diet:

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

Do you want to 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) _____

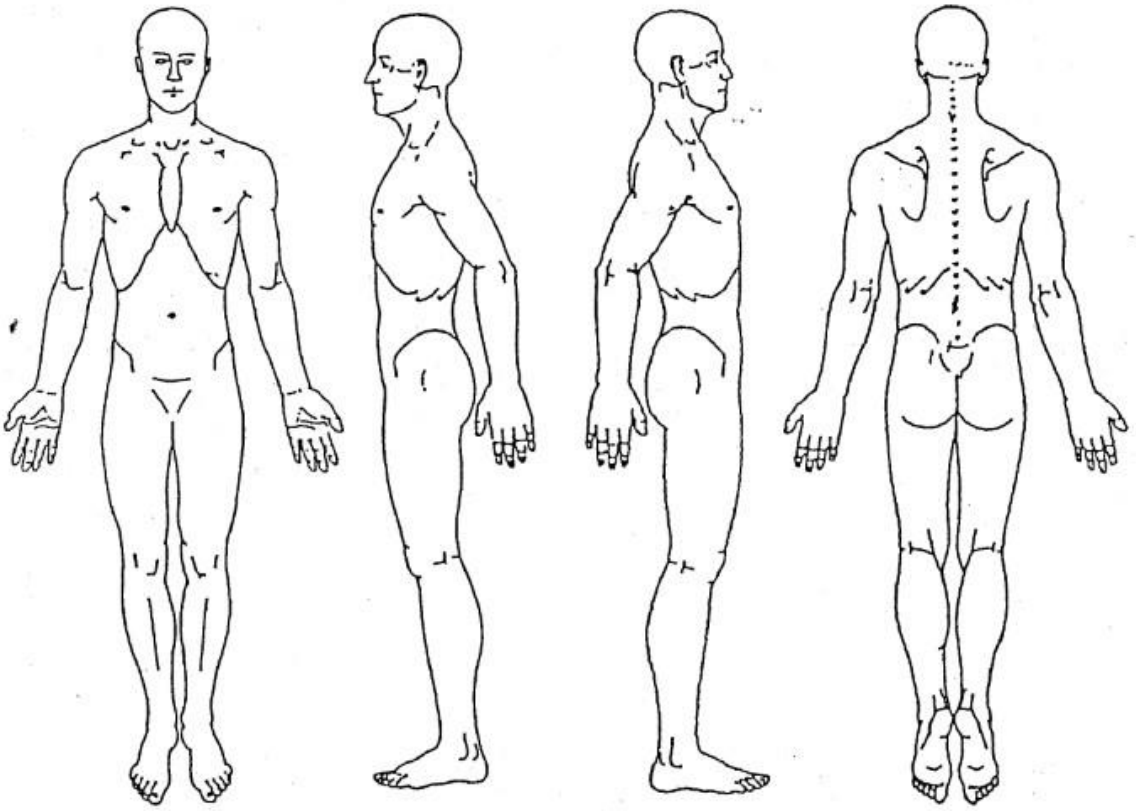
How much confidence do you have in your body's ability to heal if given the right nutrients and natural therapies (1=low, 10=high) _____

Pain Drawing

Name: _____ Date: _____

Using the following descriptive symbols, draw the location of your pain on the body outlines below. In addition, mark the level of your pain on the pain line at the bottom of the page.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
^^^^	ZZZZ	OOOO	.....	////////	XXX
^^^^	ZZZZ	OOOO	.....	////////	XXX



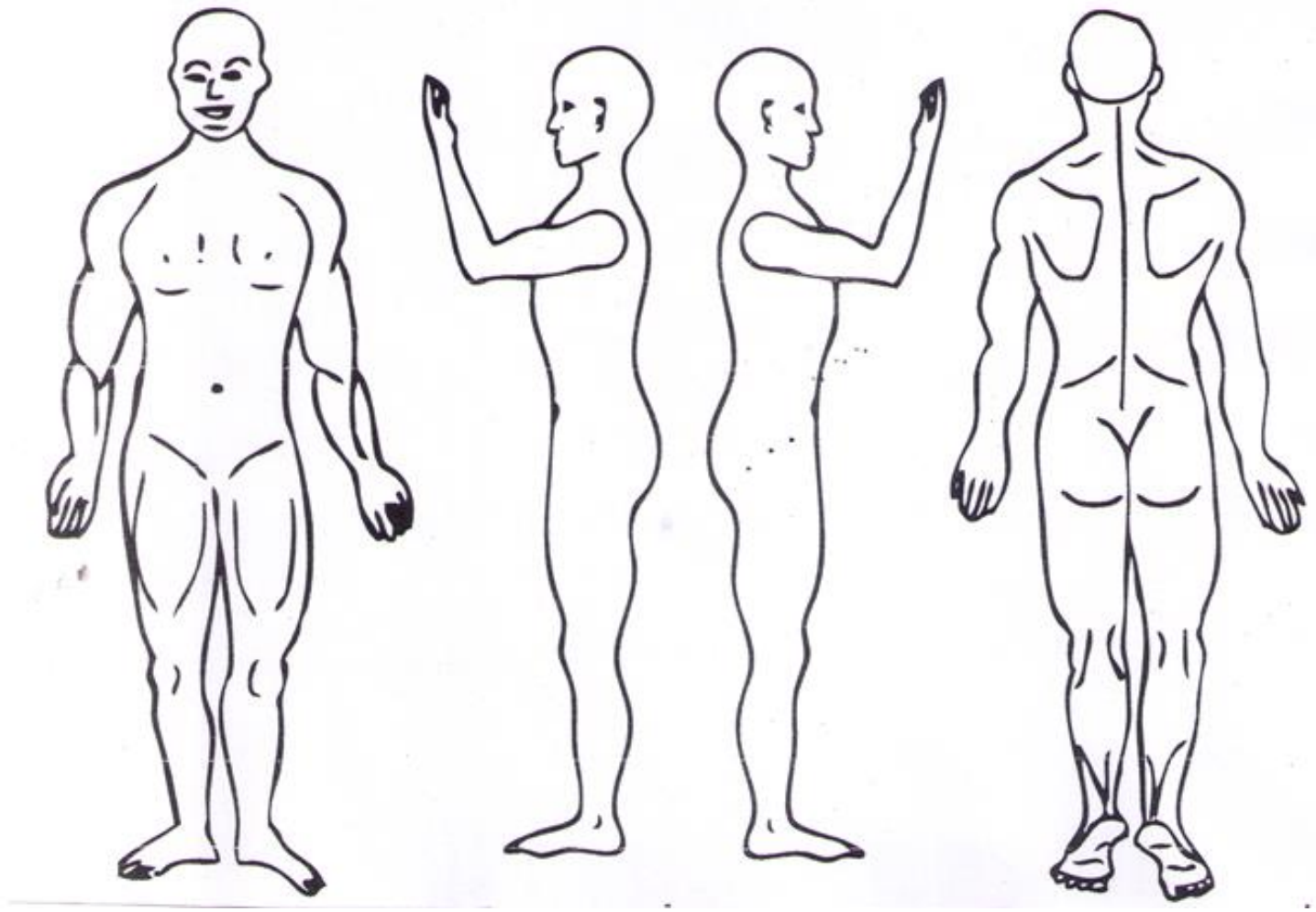
Place a slash through this line indicating your current level of pain.

No Pain |....|....|....|....|....|....|....|....|....|....|....|....|....|....|....|....|....|....|....|....| Worst possible pain

INJURY & SCAR CHART

Name: _____

Date: _____



Front Left Side Right Side Back

Draw Scars and other injuries (hilighting the area of injury and then drawing a line to the side to describe). Include age or year of injury and what happened (ex. Broken Femur from car accident-14yrs old). Include all injuries from Day 1 of life! Injuries can include stitches, broken bones, fractures, sprains, surgeries (major or minor), c-sections, episiotomies, infections, 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.