

Tree of Life Quantum Biofeedback  
Kim Fedderly RPh, PharmD, MS Holistic Nutrition  
Wellness Educator, Certified Quantum Biofeedback Specialist  
406.270.7957  
[kimfedderly@outlook.com](mailto:kimfedderly@outlook.com)  
[www.kimfedderly.com](http://www.kimfedderly.com)

## Informed Consent for Quantum Biofeedback Training or Subspace Session

### MY BACKGROUND

- Pharmacist BS/PharmD (Doctor of Pharmacy) UKCOP 1996/1997
- Clinical Staff Hospital Pharmacist 1996-2005: University of Kentucky Chandler Medical Center, Markey Cancer Center, Good Samaritan Hospital; Lexington, KY and Kalispell Regional Medical Center, MT
  - Areas of Training: IV Infusion, Critical Care, Trauma, Surgery, Internal Medicine, Family Medicine, Surgery, Pediatrics, Neonatology, Gynecology, Chemotherapy Infusion, and Hematology/Oncology/Bone Marrow/Stem Cell Transplant.
- Retail Pharmacist 2005-2012: Super 1 Foods Good Medicine Pharmacy Whitefish/Columbia Falls, Montana.
- Masters in Holistic Nutrition (and Natural Health) CCNH 2008-2011
- Wellness Educator 2012-2017: Wellness Education Center, Kalispell, MT
  - Areas of Teaching: Juice Fasting, Detoxification, Nutrition, Food Prep, Raw Living Foods/Sprouting/Juicing/Healthy Foods, Digestive Health, Food Allergies, Thyroid, Adrenal, Environmental Toxicity, Diabetes, Health Reboot Programs, Cancer. Emotional and Quantum Healing Home Studies (2016-2022)
- Wellness Educator 2017-2021: Big Sky Specialty Compounding and Holistic Pharmacy, Kalispell, MT
  - Areas of Focus: Bio-Identical Hormones, Adrenal, Thyroid, Nutrition, Digestion, Emotion/Mood, Herbal and Vitamin/Mineral Supplements.
- Relief Compounding Pharmacist 2016-2018: Montana Compounding Pharmacy, Missoula, MT
- Holistic Compounding Pharmacist 2017-2021: Big Sky Specialty Compounding and Holistic Pharmacy, Kalispell MT
  - Patient provider relationship with Functional Medicine/Integrative Health Care Prescribers, ND, DDS, & DVM
  - Certified in Female Bio-Identical Hormones C4 PCCA 2020-2021
    - Ex. Estriol, Estradiol, Estrone, Progesterone, Testosterone, DHEA, Cortisol, Thyroid hormones
    - Customized Formulation Compounding, Balancing, Therapies, Counseling, Dosing, Monitoring, Symptoms
  - Areas of Focus: Natural Health Vitamins and Supplements, Bio-Identical Hormones, Thyroid, Adrenal, COVID supportive medications/supplements, Pain Creams, and innovative or alternative dosage forms not available through regular pharmacy or manufacturer. Connecting clients to optimal providers and needs.
- National Certified Quantum Biofeedback Specialist BANHS August 2022

In 2021, I had multiple unforeseen life-change awakening moments and the opportunity to purchase a Quantum Biofeedback Device. I have been a private client, geek, and health beneficiary of quantum biofeedback technology for over 7 years. I incorporated it with my clients with longstanding health imbalances through referring them to a colleague. With my love for teaching, researching, and private Wellness Education in the field of nutrition and natural health, Quantum Biofeedback was a natural next step that fit perfectly in my career to serve others out of love. Ask me what you can really benefit from with sessions.

With my knowledge and experience, I work out of love to help reduce stressors, electrical balance, educate, advocate, and empower clients to recover health, happiness, and longevity in the journey of life. The body is designed to heal when we remove resistance, release stressors, and identify or correct imbalances. I believe in your right to educate yourself regarding health care options.

**DISCLOSURE** I am licensed as a pharmacist and certified as a biofeedback specialist. I can assist in the safe selection, proper use, dosage, and contraindications of "over the counter" medications and supplements within the scope of my practice. I cannot prescribe pharmaceutical prescription medications. I am not licensed as a physician, psychologist, or chiropractor. By law, I cannot diagnose, treat, cure, mitigate, lessen, or prevent any medical or psychological disease, disorder, or condition. I cannot instruct a client to discontinue a medically prescribed treatment. The State of Montana currently does not have standards for individuals providing "unlicensed" health care services. I can educate you and help "train" your body on what to do to assist the body to heal and reduce stressors through the Quantum Biofeedback Device.

**BIOFEEDBACK** is defined as "to give back information about life". Anything you can measure, you can change it. It is a complementary and alternative medicine technique, which enables an individual to learn to change some physiological activities for the purpose of improving health. With the biofeedback, the subject is connected to the biofeedback device with sensors to measure and receive information (feedback) about the body (bio) electric. The biofeedback sensors use mild electrical impulses that measure skin temperatures known as Electro Dermal Response (EDR), which teaches the individual to make subtle bodily changes, such as relaxing certain muscles, to achieve desired results, such as reducing pain or stressors in the body. The instrument utilized in the training sessions is called the QuEx-ED Quantum Biofeedback medical device is an FDA registered device. The device uses a medically safe pulse (micro current) that connects directly to the client with a headband, ankle, and wrist straps to measure EDR. The "FDA approved scope of my practice" through the use of this biofeedback system includes stress reduction training programs for relaxation training, pain management, muscle re-education and brainwave training. Traditional biofeedback is a measurement that causes the client to make a CONSCIOUS change after seeing the results. Common instruments include: scale, blood pressure cuff, pulse ox, thermometer, ECG, EEG, and more. A QUANTUM biofeedback device works on the subconscious level of the client to identify areas out of electrical balance or stressors and send a correctional frequency to create balance and re-educate the body in what is normal (ex. Organ/tissue/emotion/toxin/allergen/environment). Biofeedback training is a complement, not a substitute, for medical or psychological treatment, and any ongoing treatment should not be discontinued without advice of your treating physician. Biofeedback is a complement, not a substitute for medical advice or treatment. Clients may be referred to a qualified practitioner if needed. If the device is used long distance without straps it is called Quantum Subspace Session and can no longer be classified as biofeedback by the registration of the device. Ask me!!!!

**CONFIDENTIALITY** I understand my information is confidential between Kim Fedderly and myself and will not be disclosed outside of this office without written consent, unless required by law. Your information will not be shared or sold to anyone.

**PAYMENT** I agree to pay for services in full at the time of service or online invoice. Quantum biofeedback training or Subspace is not billed to or covered by insurance. You may buy a package for significant cost savings. A Super bill can be provided via your Square card payment or manual invoice if needed for deduction from HSA/Flex Spending accounts or tax purposes on request.

**BIOFEEDBACK TRAINING OPTIONS** Each client has different needs to bring the body into balance. Client therapy/training sessions can range from 45-120 minutes maximum. With acute imbalances (ex. pain management) a client may need a weekly session until symptoms subside and then choose how often they want a therapy. Therapy is not recommended more often than every 72 hours. Expectations: For every year of "imbalance" it takes about 1 month of lifestyle changes, nutrition/detoxification, & biofeedback training to bring the body into balance. Most benefit from a minimum of 2 sessions, some need 5-12 for recovery.

I understand that the quantum biofeedback therapist is **not a licensed allopathic doctor and cannot diagnose or prescribe**. Quantum biofeedback therapy is used for stress reduction, pain management, muscle re-education in addition to wellness consultations for lifestyle, behavioral, stressors, and imbalances. There is no current licensure requirement for the quantum biofeedback therapist in the state of Montana. I understand that it is my responsibility to change bad behaviors to help my body deal with distress naturally through awareness and education. It is important to disclose any information about your allergies, chemical sensitivities, or being highly sensitive person to modify training and minimize side effect risks.

**CONSENT** Your signature below indicates that you have read and understood the information in this document and that you consent to Quantum Biofeedback Training or Subspace Session under the provisions stated. If you do not understand or consent to anything stated in this document, it is your responsibility to request and receive clarification before signing. You are in full charge of your own healing decisions. By signing below, you unconditionally release Kim Fedderly and the business from any liability connected with information or biofeedback training received.

---

Client/Minor/Pet Printed Name

Client/Owner/Parent or Guardian Signature

Date

---

Phone

Email

Emergency Contact/Phone

---

Address

***Would you like to receive a monthly email with recipes, health topic, updates, etc? (Yes/No)***

*PARENTS/GUARDIANS OF MINOR CLIENT: I attest that I have full legal authority to make decisions for the minor named above, and that I give my permission for him/her/pet to undergo biofeedback training.*

## Quantum Biofeedback Intake Form

### Tips to enhance your session:

- I have a short video link on my website if you would like to learn about resonate frequency!
- Complete the form below to allow more time for biofeedback training and for each subsequent session give any changes as lifestyle is improved. You can email this form a few days ahead of time so it can be entered into the computer prior to the session. Otherwise completing the form and bringing it to the session still saves time.
- Drink plenty of water for the day before and of your session to enhance electricity in the body, dehydration can cause detoxification symptoms.
- Only wear jewelry you wear all the time (like a wedding ring). You may bring a piece of jewelry to energize with your session. You can also remove watches.
- Please keep your phone off your body during the session.
- We will be placing straps around your ankles, wrists, and head so wear clothing to allow easy access to bare skin.

Full Birth Name and Marriage last name \_\_\_\_\_

Date of Birth (MM/DD/YYYY) \_\_\_\_\_

Place of Birth (City, State) and country if outside USA \_\_\_\_\_

Circle Gender: Male Female Both

Who referred you? \_\_\_\_\_

Answer questions below with the first thing that pops in your head! It is a general health rating scale used by the biofeedback device and not a stress to have "exact" numbers. This is a weighed value in the software program.

\_\_\_\_\_ Rate Happiness on a scale of 1-10 (*1 is low and 10 is high Happiness*)

\_\_\_\_\_ Number of Organs Removed (*ex. Tonsils, gallbladder, ovaries, appendix, spleen, kidney, uterus, testicle*)

\_\_\_\_\_ Number of Synthetic Pharmaceutical Drugs (Medications and Over the Counter) used currently

\_\_\_\_\_ Times you smoke or use tobacco or nicotine products a day

\_\_\_\_\_ Number of steroid type drugs used in the last year (including hydrocortisone/cortisol for adrenal)

\_\_\_\_\_ Number of **metal fillings/dental amalgams** (silver/gold/porcelain) currently in mouth

\_\_\_\_\_ Number of street drugs used monthly (including marijuana, psychedelics, narcotics, cocaine, heroin, etc)

\_\_\_\_\_ Number of known allergies (*ex. food, inhalants/environmental, skin, drug*)

\_\_\_\_\_ Number of unresolved mental factors (mental aggravators, anxiety, depression, fear)

\_\_\_\_\_ I am responsible for my mind-body-spirit (scale of 0-10 being most responsible for health/body)

\_\_\_\_\_ *Do you think this health imbalance is due to genetics/stressors/others/emotions?*

\_\_\_\_\_ Approximate % percent of Whole Plant foods in Diet (*ex, whole grains, nuts/seeds, legumes, vegetables fruit*)

\_\_\_\_\_ Approximate % percent of Fat in diet (*ex, meat fat, nuts, avocado, salad dressings, butter/oils*):

\_\_\_\_\_ Overall Personal Stress 1 out of 10:

### **If >8 Overall Personal Stress is High this section is Optional:**

CHECK or RATE APPROPRIATE Below as how stressful on a scale of 1-10 being highest stress

\_\_\_ Interpersonal Stress?

Circle if Problem with: Sweat, Urine, Mucous, Menses, Breath, Skin, Sleep?

\_\_\_ Job or School Stress?

\_\_\_ Struggle with Self?

\_\_\_ Struggle with Money?

\_\_\_ Stress from Sickness?

\_\_\_ Stress from Family?

\_\_\_ Problem with bowels?

- \_\_\_\_\_ How many times a day to you pray, meditate, deep breathe, or use stress reduction?
- \_\_\_\_\_ Number of Root Canals
- \_\_\_\_\_ Number of sugar type products/servings per day (*include drinks, fruit, sweets, power bars, processed foods*)
- \_\_\_\_\_ Number of exercise sessions/week (20 minutes+):
- \_\_\_\_\_ Number of alcoholic drinks/day average:
- \_\_\_\_\_ Number of cups of coffee/tea/caffeine/chocolate per day:
- \_\_\_\_\_ Number of EXTREME toxic exposures in lifetime:  
(*ex. Excessive radiation, insecticides, pesticides, chemicals, herbicides, industrial, job exposures, beauty shop toxins*)
- \_\_\_\_\_ Number of major injuries in past
- \_\_\_\_\_ Number of major infections (chronic, past, and present) (*ex. Covid, Mono/EBV, sepsis, major infections*)
- \_\_\_\_\_ Number of 8oz=1 cup glasses of water per day
- \_\_\_\_\_ How many pounds overweight
- \_\_\_\_\_ Heart Pacemaker
- \_\_\_\_\_ Brain/Parkinson's Implant
- \_\_\_\_\_ Seizure Disorders
- Any Inherited Disorders? \_\_\_\_\_
- \_\_\_\_\_ Pregnant?      \_\_\_\_\_ How Many Weeks:
- \_\_\_\_\_ Top Class Athlete?
- \_\_\_\_\_ Any tissues that need to be accepted and not inflamed? (*Implants, hardware, transplants*)
- \_\_\_\_\_ Are you electrically or chemically "sensitive". If you experience discomfort we can reduce the energy.

What results would you like to see for this session? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Brief Summary of health issues: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Top 2 Stressors/health issues you would prioritize for this session(s):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Emotional release needs?  
 \_\_\_\_\_  
 \_\_\_\_\_

**Optional:** If you could write a script or prayer of what you would like your body to do physically or an area to bring emotional balance. What would it look like for the situation healthy? It can be a sentence or word.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

# Nutrition and Health Intake Form

Kim Fedderly, PharmD, MS Holistic Nutrition, Certified Quantum Biofeedback Specialist  
[www.kimfedderly.com](http://www.kimfedderly.com) Email: kimfedderly@outlook.com  
406-270-7957

Name \_\_\_\_\_ Telephone Number(s) \_\_\_\_\_ Date \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Birthdate \_\_\_\_\_ Email \_\_\_\_\_ Children? \_\_\_\_\_ How Many? \_\_\_\_\_

(Circle) Gender: M/F

Marital Status: Single Single-Parent Married Divorced Widowed

How did you hear about us? \_\_\_\_\_

→Do You Wish to Receive Monthly Wellness Email for Recipes, Education, Updates, Events & Classes (Yes/No)

## Top Health Concerns (Order of Importance) –We may only get a few in one session depending on depth.

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

## Past Pertinant Medical History/Surgeries/Hospitalizations & Dates (At least past 2 years)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Other Health Care Providers (Medical Doctor/Naturopath/Chiropractor/Acupuncture/Dental/Herbal/Biofeedback, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
Last Physical \_\_\_\_\_

## Pertinent Labs/Scans/Tests (may attach separately, please bring in any labs or have doctor fax to 755-8432)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Family History of Disease (ex. Heart, Cancer, Mental Illness, Diabetes, Stroke, Cholesterol, auto-immune)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Allergies/Intolerances (Medication/Food/Environment) & Reactions

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Nutritional/Vitamins/Herbal/Essential Oil/Homeopathic Supplements

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Regular Use of (Circle)

Antacids (Type \_\_\_\_\_) Tylenol/Acetaminophen Anti-Yeast/Fungal  
Laxatives (Type \_\_\_\_\_) Birth Control Pills Aspirin  
Stool Softeners Antibiotics  
Anti-Inflammatories (Ibuprofen, Aleve, Advil, Motrin, prescription)

List Other Over the Counter Medications (& how often)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prescription Medications

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How Motivated are you to change Nutrition, Habits & Lifestyle to be Well?? \_\_\_\_\_

Dietary Preferences

How much water do you drink a day? \_\_\_ oz./glasses/liters Water Type: Bottled, City, Filtered, or Well?

Do you eat breakfast? \_\_\_\_\_ Do You Eat for Hunger or Emotions? \_\_\_\_\_

Diet Preferences: Standard American Diet Organic (Yes/No) Vegetarian Vegan Paleo Adkins  
Ketogenic High Protein Whole Foods Auto-Immune Living Foods Gluten, Soy or Dairy Free

Prepare your meals at home (\_\_\_ %) vs. eating out (\_\_\_%) Where do you eat out? \_\_\_\_\_

Estimate Percentage of Processed Food Consumption (Fast Food, Packaged Food in Box, Bag, Can) \_\_\_%

Estimate Percentages of Diet Animal (meat/dairy/eggs) \_\_\_ % vs. Plant \_\_\_% Based Foods

What are your sources of protein? Meat Dairy Protein Powders (type \_\_\_\_\_) Nuts/Seeds  
Eggs Beans Whole Grains Vegetables/Plants

If/What Animal Protein Types (Circle all that Apply)? Organic (Yes/No) Pork Buffalo

Eggs (Organic /Conventional) Wild Game Chicken/Turkey (Conventional or Free Range)

Beef (Conventional or Grass Fed) Fish (list types \_\_\_\_\_) Other: \_\_\_\_\_

Do you consume cow/goat dairy? \_\_\_\_\_ How Much? \_\_\_\_\_ oz/servings

What types? Cheese Milk Creamer Ice Cream Cottage Cheese Yogurt/Kefir

How much meat/dairy/eggs/animal proteins do you consume daily? \_\_\_oz., \_\_\_gm. or \_\_\_ servings

If you know, What would you think your dietary percentages consumed?

\_\_\_ % Carbohydrates (Vegetables, Fruits, Legumes, Whole Grains [Breads, Pasta, Rice])

\_\_\_ % Protein (Vegetables, Legumes, Whole Grains, Meat, Dairy, Eggs)

\_\_\_ % Fats (Oils, Nuts, Avocados, Seeds, Meat, Dairy, Eggs)

\_\_\_ % Dessert/Sugar Foods/Refined Grains [white rice, pasta, white breads, white flour]

Circle What You Consume in your Regular Diet/Lifestyle

**Alcohol:** Wine Beer Liquor How Much? \_\_\_day/week

**Sweetness:** Sugar Honey Maple Syrup Xylitol Stevia Truvia Splenda (Sucralose) Ace-Sulfame K  
 Aspartame (NutraSweet/Sweet N Low/Equal) Splenda (Sucralose) High Fructose Corn Syrup  
 Erythritol Monk Fruit Comments or How much in a day? \_\_\_\_\_  
 Pastry Cookie Candy Cake Donut Ice Cream How often?\_\_\_\_\_ per day/week

**Saltiness:** Sea Salt Iodonized Salt MSG & similar Alpine Touch Herbs

**Cooking Style:** \_\_\_% Uncooked/Raw \_\_\_ % Cooked Microwave Fried Foods

**Oils/Fats:** Shortening Crisco Margarine Butter/Ghee Olive Vegetable Grapeseed  
 Canola Corn Sunflower Safflower Soy Peanut Earth Balance  
 Avocado Oil Hemp Flaxseed Cottonseed Fish Krill Cod Liver  
 Avocados Chia Roasted Nuts/Seeds Raw Nuts/Seeds Other: \_\_\_\_\_  
 Salad Dressing? List favorites \_\_\_\_\_

**Beverages:** Soda Sparkling Water Coffee (Regular or Decaf?) Regular Tea Green Tea  
 Mate Herbal Tea Crystal Light Fruit Juice Vegetable Juice Vitamin Water

**Ferments:** Sauerkraut/Kimchi Yogurt/Kefir Kombucha Kevita Probiotics

List Your Normal Foods for Each Meal

Breakfast \_\_\_\_\_  
 \_\_\_\_\_

Lunch \_\_\_\_\_  
 \_\_\_\_\_

Dinner \_\_\_\_\_  
 \_\_\_\_\_

Snacks \_\_\_\_\_  
 \_\_\_\_\_

Eating Habits

Typical Meal Portion Size? \_\_\_\_\_ (can express in fist size) Feel like you under eat/overeate?

How many hours between your dinner/snack and bedtime? \_\_\_\_\_ Hours

Do You Chew Your Food Well or Inhale/Swallow Like a Snake?? \_\_\_\_\_

Do you sit down to eat meals or eat on the go? \_\_\_\_\_

What foods are difficult for you to digest (Indigestion, gas, bloating, slow to digest) \_\_\_\_\_  
 \_\_\_\_\_

List any known food intolerances \_\_\_\_\_  
 \_\_\_\_\_

Are you interested in food intolerance/allergy testing due to digestive issues? \_\_\_\_\_

Favorite Foods \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What foods do you crave the most? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What are unhealthy foods you have a weakness for and need a healthier substitution? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Lifestyle**

Exercise? \_\_\_\_\_ Type(s) \_\_\_\_\_  
How Often \_\_\_\_\_ Occupation \_\_\_\_\_ Hours/week \_\_\_\_\_  
Biggest Source of Stress? \_\_\_\_\_  
How do you De-Stress? \_\_\_\_\_  
Spiritual Practice (optional)? \_\_\_\_\_  
Sleep: \_\_\_\_\_ hours/night If you Wake up Frequently, why? \_\_\_\_\_  
Height \_\_\_\_\_ Optimal Weight \_\_\_\_\_ lb. Current Weight \_\_\_\_\_ lb.

**Unresolved Emotions (Circle)**

Anger Unforgiveness Abuse Neglect Stress Fear Grief Hopeless Anxiety Depression Other \_\_\_\_\_

**Toxicity/Exposure (Circle/fill in)**

Long Term Exposure to Solvents/Paints/Beauty Salon/Chemicals/Herbicides/Pesticides? \_\_\_\_\_  
Exposure to Round-up (Glyphosate)? Chemotherapy? Eat GMO Foods? Swim in Pool/Hot Tub?  
Eat/store/cook/freeze in plastics? \_\_\_\_\_ Metallic Taste in Mouth? \_\_\_\_\_ Radiation Exposure?  
Metal Exposure: Mercury \_\_\_\_\_ Lead \_\_\_\_\_ Aluminum \_\_\_\_\_ Fluoride \_\_\_\_\_ Other \_\_\_\_\_  
Aluminum Cookware Aluminum in Antiperspirant Dry Clean Clothes  
Silver Dental Fillings Current # \_\_\_\_\_ # Removed \_\_\_\_\_ When \_\_\_\_\_ Root Canals? \_\_\_\_\_  
Unhealthy Teeth/Gums/Gum Disease? Describe \_\_\_\_\_  
Mold exposure in your home/work? \_\_\_\_\_ New House or Office Building in the Last 5 years? \_\_\_\_\_  
Other Toxicity or Exposures?? \_\_\_\_\_

**Review of Symptoms (You may circle word or give it severity/frequency ranking)**

0=never 1=Mild/Rarely/Monthly 2=Moderate/Occasionally/Weekly 3=Severe/Frequently/Daily P=Past/No longer present

**Nutrients**

Tongue Issues	0 1 2 3 P	Itchy Skin	0 1 2 3 P
Cracked Corners of Lips	0 1 2 3 P	Skin Issues _____	0 1 2 3 P
Poor Dream Recall	0 1 2 3 P	Nail Issues, Spots or Ridges	0 1 2 3 P
Leg Cramps	0 1 2 3 P	Poor Taste/Smell	0 1 2 3 P
Restless Legs	0 1 2 3 P	Poor wound/cut Healing	0 1 2 3 P
Crave Ice/Crunching	0 1 2 3 P	Osteoporosis/Osteopenia	0 1 2 3 P
Dry Skin	0 1 2 3 P	Cracking/Popping Joints	0 1 2 3 P

**Blood Sugar & Metabolism**

Crave Sugar or Carbohydrates	0 1 2 3 P	Excess Thirst	0 1 2 3 P
Low Blood Sugar	0 1 2 3 P	Fatigue after sugar	0 1 2 3 P
Shaky or jittery if skipped meal	0 1 2 3 P	Darkening of Skin Folds	0 1 2 3 P
Hungry Often/Snack Frequently	0 1 2 3 P	Bloating after sugar	0 1 2 3 P
Wake up after falling asleep	0 1 2 3 P	Insulin Resistance	0 1 2 3 P
Excess Appetite	0 1 2 3 P	Gestational Diabetes	0 1 2 3 P
Loss of Appetite	0 1 2 3 P	Children over 9lb @ birth? Yes/No	
Eating relieves Fatigue or Irritability	0 1 2 3 P	Diabetes/Pre-diabetes Diagnosis	0 1 2 3 P
Frequent/Excess Urination	0 1 2 3 P	HgA1C? _____	

**Immunity**

How often do you get colds/year? \_\_\_\_\_/yr.  
How often do you get flu/year? \_\_\_\_\_/yr.  
Other infections? \_\_\_\_\_/yr.  
\_\_\_\_\_

Optional History (Circle:) Epstein Barr/Mono CMV  
Shingles Herpes Cold Sores Canker Sores  
Last Vitamin D Level \_\_\_\_\_ Date \_\_\_\_\_  
Take Vitamin D daily? \_\_\_\_\_ iu

**Cardiovascular/Blood**

Chest Pains/Angina	0 1 2 3 P
Heart Palpitations/Arrhythmias	0 1 2 3 P
Enlarged Heart/Tired Heart	0 1 2 3 P
Ankles or Hands Swell	0 1 2 3 P
Shortness of Breath with exertion	0 1 2 3 P
High Altitude Discomfort	0 1 2 3 P
High Blood Pressure	0 1 2 3 P
Low Blood Pressure	0 1 2 3 P
Homocysteine Testing?	Yes/No

Elevated Cholesterol	0 1 2 3 P
Metabolic Syndrome	0 1 2 3 P
Varicose Veins	0 1 2 3 P
Bruise Easily	0 1 2 3 P
Bleed Easily	0 1 2 3 P
Poor Wound Healing	0 1 2 3 P
Anemia Type?? _____	0 1 2 3 P
High Iron Levels	0 1 2 3 P
Heart Surgery	Yes/No

**Respiratory/EENT**

Chronic Cough	0 1 2 3 P
Asthma	0 1 2 3 P
Wheezing	0 1 2 3 P
Shortness of Breath	0 1 2 3 P
Coughing up Blood	0 1 2 3 P
Post Nasal Drip	0 1 2 3 P
Sinusitis	0 1 2 3 P
Sore Throat	0 1 2 3 P
Hoarseness	0 1 2 3 P
Nasal Drip/Runny Nose	0 1 2 3 P
Ringing in Ears	0 1 2 3 P

Itchy Ears	0 1 2 3 P
Hearing Loss	0 1 2 3 P
Ear Infections	0 1 2 3 P
Ear Pain	0 1 2 3 P
Dry Eyes	0 1 2 3 P
Watery Eyes	0 1 2 3 P
Itchy/Red Eyes	0 1 2 3 P
Eye Infections	0 1 2 3 P
Vision Changes	0 1 2 3 P
Poor Night Vision	0 1 2 3 P

**Endocrine**

Enlarge Glands	0 1 2 3 P
Cold Hands and Feet	0 1 2 3 P
Intolerance to Cold	0 1 2 3 P
Intolerance to Heat	0 1 2 3 P
Thinning, Course, or Brittle Hair	0 1 2 3 P
Thinning Outer Eyebrows	0 1 2 3 P
Dry Skin	0 1 2 3 P
Brittle Nails	0 1 2 3 P
Foggy Brain	0 1 2 3 P
Fatigued All Day/Night	0 1 2 3 P
Fatigued AM, best after 10am	0 1 2 3 P
Tend to be a "night" person	0 1 2 3 P
Trouble getting to sleep (wired)	0 1 2 3 P
Difficulty Losing Weight	0 1 2 3 P
Weight Gain Around Middle	0 1 2 3 P
Constipation	0 1 2 3 P

Weak Muscles	0 1 2 3 P
Goiter/Swelling @ Neck	0 1 2 3 P
Puffy Eyes in AM	0 1 2 3 P
High Cholesterol	0 1 2 3 P
Depression	0 1 2 3 P
Anxiety	0 1 2 3 P
Insomnia	0 1 2 3 P
Low blood pressure	0 1 2 3 P
Crave salt	0 1 2 3 P
Excessive Stress	0 1 2 3 P
Feel overcommitted	0 1 2 3 P
Anxious or Nervous	0 1 2 3 P
Feel Energized with Exercise	0 1 2 3 P
Feel Fatigued with Exercise	0 1 2 3 P
Dizziness upon standing	0 1 2 3 P
Need coffee/caffeine to get going	0 1 2 3 P

**Bladder/Kidney**

Kidney Stones	0 1 2 3 P
Frequent Urination	0 1 2 3 P
Incontinence/Dribbling	0 1 2 3 P
Cloudy, bloody urine	0 1 2 3 P
Urine has Strong Odor	0 1 2 3 P

Burning with Urination	0 1 2 3 P
Urinary Tract Infection	0 1 2 3 P
Blood in Urine	0 1 2 3 P
Bubbles in Urine	0 1 2 3 P
Urination during the night	0 1 2 3 P

**Muscle/Skeletal**

Joint Pain	0 1 2 3 P
Joint Swelling/Stiffness	0 1 2 3 P
Which ones? _____	
Muscle Weakness	0 1 2 3 P
Muscle Pain	0 1 2 3 P
Fibromyalgia	0 1 2 3 P

Gout	0 1 2 3 P
Back Pain	0 1 2 3 P
Numbness or Tingling extremities	0 1 2 3 P
Area(s) _____	
Injuries	0 1 2 3 P
Area(s) _____	

**Liver/Gallbladder**

Intolerance to greasy foods 0 1 2 3 P  
 Pain under right ribcage 0 1 2 3 P  
 Pale, Yellow or Gold Stool 0 1 2 3 P  
 Skin rashes or disturbances 0 1 2 3 P  
 Dark Urine 0 1 2 3 P  
 Gallbladder attacks 0 1 2 3 P  
 Easily hung over if you have wine 0 1 2 3 P

History of Drug or Alcohol Abuse 0 1 2 3 P  
 History of Hepatitis 0 1 2 3 P  
 Sensitive to Chemicals, Perfumes, Cleaning Agents,  
 Tobacco, Diesel Fumes 0 1 2 3 P  
 Sweat Profusely 0 1 2 3 P  
 Hot Flashes ~2-4am 0 1 2 3 P

**Digestion** (Optional: Ask for Comprehensive Digestive Health Assessment or download @ [www.kimfedderly.com](http://www.kimfedderly.com) if unresolved Digestive Issues)

Stool Consistency: Normal/Soft like a Banana, Hard/Pebbles, Floating, Mucous, Oily, Blood, Loose/Watery, Irritable Bowel

Bowel Movements \_\_\_\_\_/day or week

Is food undigested in Stool? Yes/No

GERD/Acid Reflux 0 1 2 3 P

Stomach Ulcers 0 1 2 3 P

Stomach Pain 0 1 2 3 P

Burping after Meals 0 1 2 3 P

Bloating 0 1 2 3 P

Gas 0 1 2 3 P

Nausea 0 1 2 3 P

Vomiting 0 1 2 3 P

Dark Foul Stools 0 1 2 3 P

Colon Polyps 0 1 2 3 P

Hemorrhoids 0 1 2 3 P

Constipation 0 1 2 3 P

Diarrhea 0 1 2 3 P

Irritable Bowel Syndrome/Disease 0 1 2 3 P

Leaky Gut 0 1 2 3 P

Food Sensitivities 0 1 2 3 P

Lactose Intolerance 0 1 2 3 P

Celiac or Gluten Intolerance 0 1 2 3 P

Eczema/Dermatitis/Psoriasis 0 1 2 3 P

Rosacea 0 1 2 3 P

Diverticulitis 0 1 2 3 P

Teeth Grinding 0 1 2 3 P

Gas/Bloating worsened with sugar 0 1 2 3 P

Feel bad with grains/starches 0 1 2 3 P

Foggy Brain with grain/sugar/starch 0 1 2 3 P

Probiotics make digestion worse 0 1 2 3 P

Dark Circles Under Eyes 0 1 2 3 P

White/Yellow Coated Tongue 0 1 2 3 P

Itchy: Ears/Genitals/Anus or Mouth 0 1 2 3 P

Acne 0 1 2 3 P

Hives/Rashes 0 1 2 3 P

Athletes Foot or Fungal Nails 0 1 2 3 P

**Nervous System** (Optional: Ask for Comprehensive Anxiety/Depression Symptom Checklist or download from [www.kimfedderly.com](http://www.kimfedderly.com))

Memory Loss 0 1 2 3 P

Confusion 0 1 2 3 P

Anxiety 0 1 2 3 P

Depression 0 1 2 3 P

Irritability 0 1 2 3 P

Insomnia 0 1 2 3 P

Nervousness 0 1 2 3 P

Head Injury When? \_\_\_\_\_ 0 1 2 3 P

Seizures 0 1 2 3 P

Tremors 0 1 2 3 P

Nerve Injuries 0 1 2 3 P

Neuropathy 0 1 2 3 P

**Female**

Vaginal Discharge 0 1 2 3 P

Ovarian Cyst 0 1 2 3 P

Fibrocystic Breast 0 1 2 3 P

Breast Pain 0 1 2 3 P

Breast Lumps 0 1 2 3 P

Loss of Sex Drive 0 1 2 3 P

Vaginal Yeast Infections 0 1 2 3 P

Female Surgery Type ? \_\_\_\_\_ Yes/No

Heavy Periods 0 1 2 3 P

Irregular Periods 0 1 2 3 P

Length of Period \_\_\_ Days or Menopause

Flow: light medium heavy (circle)

PMS 0 1 2 3 P

Menstrual Difficulties 0 1 2 3 P

Excessive Cramping 0 1 2 3 P

Hormone Imbalances 0 1 2 3 P

**Male**

Prostate Problems 0 1 2 3 P

Elevated PSA Lab=\_\_\_\_\_ Yes/No

Decreased Urine Flow Yes/No

Difficulty with Urination, dribbling 0 1 2 3 P

Difficult to start/stop urine 0 1 2 3 P

Waking up to urinate at night 0 1 2 3 P

Interruption of urine stream 0 1 2 3 P

Testicle Pain 0 1 2 3 P

Testicle Lump 0 1 2 3 P

Loss of Sex Drive 0 1 2 3 P

Loss of Muscle Strength 0 1 2 3 P