Kim Fedderly RPh, PharmD, MS Holistic Nutrition
Wellness Educator, Certified Quantum Biofeedback Specialist
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Informed Consent for Quantum Biofeedback Training

MY BACKGROUND

- University of Kentucky College of Pharmacy 1989-1997: Pharmacist RPh BS/PharmD
- 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, 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) 2008-2011 (Clayton College of Natural Health, Online)
- 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
    - Clients of Focus: Patient provider relationship with Functional Medicine/Integrative Health Care Prescribers, Naturopaths, Dentists, and Veterinarians.
    - Certified in Female Bio-Identical Hormones C4 PCCA 2020-2021
        - 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.
- National Certified Quantum Biofeedback May 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.

With my knowledge and experience, I work out of love to help reduce stress, 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. 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.

BIOFEEDBACK Biofeedback 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. Although this training is expected to produce beneficial results, such results cannot be guaranteed. 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.

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 therapy 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 45-90 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.

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.

ARBRITRATION PROVISION Arbitration sets forth an agreement to forgo court action to settle disputes that arise between client and practitioner. Local organizations may provide arbitration services to handle such matters.

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 biofeedback training 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

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.

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Tips to enhance your session:

- ❒ 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 day 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

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 called the "Suppression or Oppression to Cure" scale or the SOC 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:

High Stress Optional:

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

____*Interpersonal Stress?*
____*Job or School Stress?*
____*Struggle with Self?*
____*Struggle with Money?*
____*Stress from Sickness?*
____ *Stress from Family?*
____ *Problem with bowels?*
____ *Problem with sweat?*
____ *Problem with urine?*
____ *Problem with mucous?*
____ *Problem with menses?*
____ *Problem with breath?*
____ *Problem with skin?*
____ *Problem with sleep?*

_____How many times a day to you pray, meditate, deep breathe, or use stress reduction techniques?
_____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)*

What results would you like to see for this session? _____
_____
_____

Current Symptoms or areas of Dis-Ease, Medical Disease Diagnosis, Pertinent Info?
_____
_____
_____
_____
_____
_____

Emotional release needs?
_____
_____

Optional: If you could write a script or prayer of what you would like your body to do physically or emotional balance we can "Invert" a group of symptoms and "replace or restore" it with that that looks like on the health side. It can be a sentence or many paragraphs. Examples: Invert asthma, inflammation, wheezing, and hyper reactivity in the lungs and restore healthy balanced reactivity to foods and the environment and normal healthy deep breathing and oxygenation to tissues in the lung. Invert excessive fear and restore faith, trust, and peaceful emotions. We can write this together, just need areas of imbalances identified below.
_____
_____
_____
_____
_____
_____

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Client/Minor/Pet Printed Name Client/Owner/Parent or Guardian Signature Date

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 receive Wellness Education.

Nutrition and Health Intake Form

Kim Fedderly, PharmD, MS Holistic Nutrition, Certified Quantum Biofeedback Specialist
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 concerns for Health (In Order of Importance)

1) _____
2) _____
3) _____
4) _____
5) _____

Past 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 (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
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/overeat?

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		Elevated Cholesterol	0 1 2 3 P
Heart Palpitations/Arrhythmias	0 1 2 3 P		Metabolic Syndrome	0 1 2 3 P
Enlarged Heart/Tired Heart	0 1 2 3 P		Varicose Veins	0 1 2 3 P
Ankles or Hands Swell	0 1 2 3 P		Bruise Easily	0 1 2 3 P
Shortness of Breath with exertion	0 1 2 3 P		Bleed Easily	0 1 2 3 P
High Altitude Discomfort	0 1 2 3 P		Poor Wound Healing	0 1 2 3 P
High Blood Pressure	0 1 2 3 P		Anemia Type?? _____	0 1 2 3 P
Low Blood Pressure	0 1 2 3 P		High Iron Levels	0 1 2 3 P
Homocysteine Testing?	Yes/No		Heart Surgery	Yes/No

Respiratory/EENT

Chronic Cough	0 1 2 3 P		Itchy Ears	0 1 2 3 P
Asthma	0 1 2 3 P		Hearing Loss	0 1 2 3 P
Wheezing	0 1 2 3 P		Ear Infections	0 1 2 3 P
Shortness of Breath	0 1 2 3 P		Ear Pain	0 1 2 3 P
Coughing up Blood	0 1 2 3 P		Dry Eyes	0 1 2 3 P
Post Nasal Drip	0 1 2 3 P		Watery Eyes	0 1 2 3 P
Sinusitis	0 1 2 3 P		Itchy/Red Eyes	0 1 2 3 P
Sore Throat	0 1 2 3 P		Eye Infections	0 1 2 3 P
Hoarseness	0 1 2 3 P		Vision Changes	0 1 2 3 P
Nasal Drip/Runny Nose	0 1 2 3 P		Poor Night Vision	0 1 2 3 P
Ringing in Ears	0 1 2 3 P			

Endocrine

Enlarge Glands	0 1 2 3 P		Weak Muscles	0 1 2 3 P
Cold Hands and Feet	0 1 2 3 P		Goiter/Swelling @ Neck	0 1 2 3 P
Intolerance to Cold	0 1 2 3 P		Puffy Eyes in AM	0 1 2 3 P
Intolerance to Heat	0 1 2 3 P		High Cholesterol	0 1 2 3 P
Thinning, Course, or Brittle Hair	0 1 2 3 P		Depression	0 1 2 3 P
Thinning Outer Eyebrows	0 1 2 3 P		Anxiety	0 1 2 3 P
Dry Skin	0 1 2 3 P		Insomnia	0 1 2 3 P
Brittle Nails	0 1 2 3 P		Low blood pressure	0 1 2 3 P
Foggy Brain	0 1 2 3 P		Crave salt	0 1 2 3 P
Fatigued All Day/Night	0 1 2 3 P		Excessive Stress	0 1 2 3 P
Fatigued AM, best after 10am	0 1 2 3 P		Feel overcommitted	0 1 2 3 P
Tend to be a "night" person	0 1 2 3 P		Anxious or Nervous	0 1 2 3 P
Trouble getting to sleep (wired)	0 1 2 3 P		Feel Energized with Exercise	0 1 2 3 P
Difficulty Losing Weight	0 1 2 3 P		Feel Fatigued with Exercise	0 1 2 3 P
Weight Gain Around Middle	0 1 2 3 P		Dizziness upon standing	0 1 2 3 P
Constipation	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		Burning with Urination	0 1 2 3 P
Frequent Urination	0 1 2 3 P		Urinary Tract Infection	0 1 2 3 P
Incontinence/Dribbling	0 1 2 3 P		Blood in Urine	0 1 2 3 P
Cloudy, bloody urine	0 1 2 3 P		Bubbles in Urine	0 1 2 3 P
Urine has Strong Odor	0 1 2 3 P		Urination during the night	0 1 2 3 P

Muscle/Skeletal

Joint Pain	0 1 2 3 P		Gout	0 1 2 3 P
Joint Swelling/Stiffness	0 1 2 3 P		Back Pain	0 1 2 3 P
Which ones?_____			Numbness or Tingling extremities	0 1 2 3 P
Muscle Weakness	0 1 2 3 P		Area(s)_____	
Muscle Pain	0 1 2 3 P		Injuries	0 1 2 3 P
Fibromyalgia	0 1 2 3 P		Area(s)_____	

Liver/Gallbladder

Intolerance to greasy foods	0 1 2 3 P	History of Drug or Alcohol Abuse	0 1 2 3 P
Pain under right ribcage	0 1 2 3 P	History of Hepatitis	0 1 2 3 P
Pale, Yellow or Gold Stool	0 1 2 3 P	Sensitive to Chemicals, Perfumes, Cleaning Agents,	
Skin rashes or disturbances	0 1 2 3 P	Tobacco, Diesel Fumes	0 1 2 3 P
Dark Urine	0 1 2 3 P	Sweat Profusely	0 1 2 3 P
Gallbladder attacks	0 1 2 3 P	Hot Flashes ~2-4am	0 1 2 3 P
Easily hung over if you have wine	0 1 2 3 P		

Digestion *(Optional: Ask for Comprehensive Digestive Health Assessment or download @ 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	Food Sensitivities	0 1 2 3 P
Is food undigested in Stool?	Yes/No	Lactose Intolerance	0 1 2 3 P
GERD/Acid Reflux	0 1 2 3 P	Celiac or Gluten Intolerance	0 1 2 3 P
Stomach Ulcers	0 1 2 3 P	Eczema/Dermatitis/Psoriasis	0 1 2 3 P
Stomach Pain	0 1 2 3 P	Rosacea	0 1 2 3 P
Burping after Meals	0 1 2 3 P	Diverticulitis	0 1 2 3 P
Bloating	0 1 2 3 P	Teeth Grinding	0 1 2 3 P
Gas	0 1 2 3 P	Gas/Bloating worsened with sugar	0 1 2 3 P
Nausea	0 1 2 3 P	Feel bad with grains/starches	0 1 2 3 P
Vomiting	0 1 2 3 P	Foggy Brain with grain/sugar/starch	0 1 2 3 P
Dark Foul Stools	0 1 2 3 P	Probiotics make digestion worse	0 1 2 3 P
Colon Polyps	0 1 2 3 P	Dark Circles Under Eyes	0 1 2 3 P
Hemorrhoids	0 1 2 3 P	White/Yellow Coated Tongue	0 1 2 3 P
Constipation	0 1 2 3 P	Itchy: Ears/Genitals/Anus or Mouth	0 1 2 3 P
Diarrhea	0 1 2 3 P	Acne	0 1 2 3 P
Irritable Bowel Syndrome/Disease	0 1 2 3 P	Hives/Rashes	0 1 2 3 P
Leaky Gut	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)*

Memory Loss	0 1 2 3 P	Nervousness	0 1 2 3 P
Confusion	0 1 2 3 P	Head Injury When? _____	0 1 2 3 P
Anxiety	0 1 2 3 P	Seizures	0 1 2 3 P
Depression	0 1 2 3 P	Tremors	0 1 2 3 P
Irritability	0 1 2 3 P	Nerve Injuries	0 1 2 3 P
Insomnia	0 1 2 3 P	Neuropathy	0 1 2 3 P

Female

Vaginal Discharge	0 1 2 3 P	Heavy Periods	0 1 2 3 P
Ovarian Cyst	0 1 2 3 P	Irregular Periods	0 1 2 3 P
Fibrocystic Breast	0 1 2 3 P	Length of Period ___ Days or Menopause	
Breast Pain	0 1 2 3 P	Flow: light medium heavy (circle)	
Breast Lumps	0 1 2 3 P	PMS	0 1 2 3 P
Loss of Sex Drive	0 1 2 3 P	Menstrual Difficulties	0 1 2 3 P
Vaginal Yeast Infections	0 1 2 3 P	Excessive Cramping	0 1 2 3 P
Female Surgery Type ?_____	Yes/No	Hormone Imbalances	0 1 2 3 P

Male

Prostate Problems	0 1 2 3 P	Interruption of urine stream	0 1 2 3 P
Elevated PSA Lab=_____	Yes/No	Testicle Pain	0 1 2 3 P
Decreased Urine Flow	Yes/No	Testicle Lump	0 1 2 3 P
Difficulty with Urination, dribbling	0 1 2 3 P	Loss of Sex Drive	0 1 2 3 P
Difficult to start/stop urine	0 1 2 3 P	Loss of Muscle Strength	0 1 2 3
Waking up to urinate at night	0 1 2 3 P		