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

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

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.*

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. Wellness Education sessions are no covered by insurance. A Wellness Education Consult 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.

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 wellness education. 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 the education received.

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		