Functional Medicine, Cellular Health & Terrain Intake Form

Please complete this form as thoroughly as possible and upload your supplement list, medication list, historical lab work, recent lab work, and any relevant diagnostic records.

Welcome — this intake is designed to help us understand your health story, current concerns, cellular resilience, terrain patterns, and safety considerations so recommendations can be more personalized and supportive.

If you are unsure of an answer, write “unsure.” You may also attach additional pages if needed.

Section 1: Basic Information

Full Name: _____

Date of Birth: _____

Age: _____

Sex: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

Email Address: _____

Occupation: _____

Marital Status: _____

Emergency Contact Name and Phone Number:

_____

Preferred Method of Contact:

_____

Section 2: Main Reason for Seeking Support

What are your top 3 health concerns or goals right now:

_____

1: _____

2: _____

3: _____

What made you decide to seek support at this time:

_____

_____

_____

How long have you been dealing with these concerns:

_____

_____

_____

What symptoms bother you the most day to day:

_____

_____

_____

What are you hoping to improve, restore, or better understand:

_____

_____

_____

Section 3: Current Symptoms

Please check all symptoms that apply currently or within the last 6–12 months.

Energy / Nervous System

☐ Fatigue	☐ Low stamina
☐ Burnout	☐ Midday crash
☐ Trouble waking in the morning	☐ Wired but tired
☐ Brain fog	☐ Poor focus
☐ Poor memory	☐ Dizziness
☐ Weakness	☐ Feeling easily overwhelmed
☐ Anxiety	☐ Low mood
☐ Poor stress tolerance	☐ Headaches
☐ Migraines	

Sleep

☐ Trouble falling asleep	☐ Trouble staying asleep
☐ Waking too early	☐ Unrefreshed sleep
☐ Snoring	☐ Night sweats
☐ Restless sleep	☐ Frequent urination at night

Weight / Metabolism

☐ Weight gain	☐ Weight loss resistance
☐ Belly fat	☐ Sugar cravings

☐ Frequent hunger	☐ Low appetite
☐ Shaky if meals are missed	☐ Blood sugar swings
☐ Feeling worse after eating	☐ Poor exercise tolerance

Digestive / Gut Health

☐ Bloating	☐ Gas
☐ Burping	☐ Reflux
☐ Nausea	☐ Constipation
☐ Diarrhea	☐ Alternating constipation/diarrhea
☐ Abdominal pain	☐ Food sensitivities
☐ Undigested food in stool	☐ Pale or floating stools
☐ Dark stools	☐ Mucus in stool
☐ History of gallbladder issues	☐ Trouble digesting fats
☐ Frequent stomach upset	

Hormones

☐ PMS	☐ Irregular cycles
☐ Heavy bleeding	☐ Painful cycles
☐ Perimenopausal symptoms	☐ Hot flashes
☐ Night sweats	☐ Vaginal dryness
☐ Low libido	☐ Mood changes
☐ Hair thinning	☐ Facial hair growth
☐ Acne	☐ Breast tenderness
☐ Hormone imbalance	☐ On hormone replacement therapy

Immune / Inflammation

☐ Frequent colds or infections	☐ Seasonal allergies

☐ Chronic inflammation	☐ Swollen glands
☐ Autoimmune condition	☐ Joint pain
☐ Muscle pain	☐ Chronic pain
☐ Sinus congestion	☐ Skin rashes
☐ Hives	☐ Slow healing

Skin / Hair / Nails

☐ Hair loss	☐ Brittle nails
☐ Dry skin	☐ Acne
☐ Eczema	☐ Rashes
☐ Easy bruising	☐ Changes in skin tone or texture

Cardiovascular / Respiratory

☐ Shortness of breath	☐ Palpitations
☐ High blood pressure	☐ Chest discomfort
☐ Swelling	☐ Cold hands/feet

Detox / Terrain Clues

☐ Chemical sensitivity	☐ Mold sensitivity
☐ Strong reactions to supplements or medications	☐ Poor tolerance to fragrances
☐ History of toxin exposure	☐ Chronic sinus issues
☐ Feeling “toxic” or inflamed	

Section 4: Medical History

List any current medical diagnoses:

_____

_____

_____

_____

List any past medical diagnoses:

_____

_____

_____

Please explain any significant diagnoses or concerns:

_____

_____

_____

Have you ever been diagnosed with any of the following?

☐ Thyroid disorder	☐ Autoimmune condition	☐ Diabetes or prediabetes
☐ Insulin resistance	☐ High cholesterol	☐ High blood pressure
☐ Heart disease	☐ Fatty liver	☐ Gallbladder disease
☐ Kidney disease	☐ Adrenal dysfunction	☐ Hormone imbalance
☐ PCOS	☐ Endometriosis	☐ Infertility
☐ Anxiety or depression	☐ Chronic infections	☐ Lyme disease
☐ Epstein-Barr virus	☐ Mold illness	☐ Cancer
☐ Osteopenia/osteoporosis	☐ Digestive disorder	☐ Celiac disease
☐ IBS	☐ IBD	☐ GERD
☐ Chronic pain syndrome	☐ Fibromyalgia	☐ Neurologic condition

Section 5: Surgical History

List all surgeries, procedures, or hospitalizations with approximate dates:

_____

_____

_____

_____

Section 6: Medications, Hormones, and Supplements

☐ Please complete and attach your current medication list.

☐ Please complete and attach your current supplement list.

☐ Please attach your current hormone / BHRT list, if applicable.

Current Prescription Medications (name, dose, frequency):

_____

_____

_____

_____

_____

Current Over-the-Counter Medications:

_____

_____

_____

_____

_____

Current Hormones / BHRT:

_____

_____

_____

_____

_____

Current Supplements:

_____

_____

_____

_____

_____

Any reactions or sensitivities to medications, hormones, or supplements:

_____

_____

_____

_____

_____

Section 7: Allergies and Sensitivities

Please list any known medication allergies:

_____

_____

_____

Please list any food allergies or sensitivities:

_____

_____

_____

Please list any environmental, chemical, mold, fragrance, or latex sensitivities:

_____

_____

_____

Section 8: Lab Work and Diagnostics

☐ Historical blood work

☐ Recent blood work

☐ Hormone labs

☐ Thyroid labs

☐ Lipid panels

☐ Glucose / insulin labs

☐ Inflammation markers

☐ Stool testing

☐ Food sensitivity testing

☐ Organic acids testing

☐ DUTCH or hormone testing

☐ Imaging (ultrasound, CT, MRI, X-ray, mammogram, DEXA, etc.)

☐ Colonoscopy/endoscopy

☐ Pathology reports

☐ Specialist consultation notes

☐ Hospital discharge summaries

☐ Operative reports

What recent lab work or diagnostics have you had completed:

_____

_____

_____

_____

_____

When was your most recent blood work:

_____

_____

_____

_____

_____

Have you had any abnormal labs or testing results in the past? If yes, please explain:

_____

_____

_____

_____

_____

Section 9: Family History

Has anyone in your immediate family had:

☐ Thyroid disease	☐ Diabetes
☐ Obesity	☐ High blood pressure
☐ High cholesterol	☐ Heart disease
☐ Stroke	☐ Cancer
☐ Autoimmune disease	☐ Dementia
☐ Depression/anxiety	☐ Osteoporosis
☐ Digestive disease	☐ Hormone-related conditions

Please explain any important family history:

_____

_____

_____

_____

_____

Section 10: Nutrition and Digestion

How would you describe your current diet:

_____

_____

_____

Do you have any known food triggers or sensitivities:

_____

How many meals do you eat per day:

_____

Do you skip meals: _____

How much water do you drink daily:

_____

Do you use electrolytes or mineral support:

_____

Do you consume caffeine? If yes, how much:

_____

Do you consume alcohol? If yes, how often:

_____

How often do you have bowel movements:

_____

Do you feel fully emptied after a bowel movement:

_____

Describe your digestion in your own words:

_____

_____

_____

Do you follow any particular food plan?

☐ No specific plan	☐ Gluten-free	☐ Dairy-free
☐ Low carb	☐ Paleo	☐ Keto
☐ Carnivore	☐ Mediterranean	☐ Vegetarian
☐ Vegan	☐ Other	

Section 11: Sleep, Stress, and Nervous System

How many hours of sleep do you get per night:

_____

Do you feel rested when you wake up:

_____

Do you snore or suspect sleep apnea:

_____

How would you rate your current stress level from 1–10:

_____

What are your biggest current sources of stress:

_____

_____

_____

How do you currently manage stress:

_____

_____

_____

Do you feel your body is often in “fight or flight”:

_____

Do you have a history of trauma, prolonged stress, or burnout that may still affect your health? Yes / No / Prefer not to answer

Section 12: Exercise and Physical Activity

How often do you exercise:

_____

What type of exercise do you do:

_____

_____

_____

How do you feel after exercise:

_____

Do you currently have pain, weakness, or limitations that affect movement:

_____

_____

_____

Section 13: Environmental and Terrain Health

Have you had any significant exposure to:

☐ Mold or water-damaged buildings	☐ Chemicals
☐ Pesticides	☐ Heavy metals
☐ Smoking / secondhand smoke	☐ Solvents
☐ Occupational toxins	☐ Air pollution
☐ Contaminated water	☐ Chronic infections

Do you have a history of:

☐ Frequent antibiotics	☐ Chronic sinus issues
☐ Recurrent yeast issues	☐ Tick bites
☐ Living or working in a moldy environment	☐ Strong chemical sensitivity
☐ Poor detox tolerance	

Please explain any known exposures or concerns:

_____

_____

_____

_____

_____

Section 14: Women's Health / Men's Health

Women

Are you currently cycling, perimenopausal, menopausal, postmenopausal, or on BHRT:

_____

Age at first period: _____

Date of last menstrual period:

_____

How regular are your cycles:

_____

Do you ovulate regularly, if known:

_____

Any history of PCOS, fibroids, endometriosis, infertility, miscarriage, or hormone-related concerns:

_____

_____

_____

Any history of breast, uterine, ovarian, or cervical concerns:

_____

_____

_____

Men

Any history of low testosterone, prostate issues, erectile dysfunction, low libido, or hormone-related concerns:

_____

_____

_____

Section 15: Safety Screening

Do you currently have or have a history of:

☐ Chest pain	☐ Shortness of breath
☐ Fainting	☐ Blood clots
☐ Stroke	☐ Seizures
☐ Cancer	☐ Pregnancy
☐ Active infection	☐ Severe mental health crisis
☐ Eating disorder	☐ Kidney disease
☐ Liver disease	☐ Unexplained bleeding
☐ Unexplained weight loss	☐ Black stools
☐ Blood in stool	☐ New severe headaches
☐ Rapid heartbeat	☐ Severe swelling

Please explain anything important we should know for your safety:

_____

_____

_____

_____

_____

Section 16: Goals and Readiness

What are your top health goals over the next 3–6 months:

_____

_____

_____

_____

_____

What would success look like for you:

_____

_____

_____

_____

_____

What have you tried in the past that has or has not worked:

_____

_____

_____

_____

_____

How ready are you to make changes right now? 1 2 3 4 5 6 7 8 9 10

What kind of support are you looking for most?

☐ Education	☐ Accountability
☐ Wellness strategy	☐ Lab interpretation
☐ Bioenergetic support	☐ Hormone-related support
☐ Root-cause guidance	☐ Other

Section 17: Upload Checklist

☐ Current medication list

☐ Current supplement list

☐ Current hormone/BHRT list

☐ Historical lab work

☐ Recent lab work

☐ Imaging/diagnostics

☐ Specialist notes

☐ Any other relevant records

Section 18: Final Notes

Is there anything else you would like us to know that has not been covered in this form:

_____

_____
_____
_____
_____
_____
_____

Acknowledgment

I understand that this intake form is used to gather health history, lifestyle information, supplement and medication use, and relevant records in order to better understand my overall wellness picture and support safe, personalized wellness recommendations.

I understand that Kelly Brink is not a medical doctor. Kelly Brink holds a PhD and doctoral training in functional and natural medicine and provides wellness education, coaching, and supportive guidance. She does not diagnose, treat, cure, or prescribe for medical conditions, and her services are not a substitute for medical care, diagnosis, or treatment from a licensed physician or other qualified healthcare.

Client Name: _____

Date: _____

Signature: _____