# Kelly Brink LLC – Comprehensive Bioenergetic Wellness Intake & Consent Form

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## Section 1: Coaching Agreement & Consent

**Provider:** Dr. Kelly Brink, PhD, DNM, DHM, RN, CHWC
**Business:** Kelly Brink LLC
**Email:** KellyBrinkLLC@gmail.com

I understand and acknowledge the following: - Dr. Kelly Brink functions in a **health & wellness coaching capacity**, not as a licensed medical provider. She does not diagnose, treat, or prescribe medications. - All services, including bioenergetic scanning and Infoceutical recommendations, are for **educational and wellness purposes only**. - Results and recommendations are not a substitute for medical care, diagnosis, or treatment. Clients should continue to work with their licensed healthcare providers for medical conditions. - I am responsible for my physical, mental, and emotional well-being during and after coaching. I will consult my physician for evaluation of any disease, persistent symptoms, or medication adjustments. - Clients with **organ/tissue transplants** or on **immunosuppressive medications** are not eligible for Infoceuticals. – Most reports are delivered **within 72 hours** after scan submission. - I consent to participate in bioenergetic scanning and wellness coaching with Kelly Brink LLC and acknowledge my informed choice to proceed. - I understand that information shared during sessions may be used to guide recommendations, but will remain **confidential** except where disclosure is required by law. - I understand that I may stop participation at any time.

**Signature:** _____ **Date:** _____

**Printed Name:** _____

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## Section 2: Personal Information

- Full Legal Name: _____
- Date of Birth: _____
- Address: _____
  _____

- Phone: _____ Email: _____
- Emergency Contact (Name/Phone/Relationship): _____
- Preferred Method of Communication (email/phone/text): _____
- How did you hear about Kelly Brink LLC? _____

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## Section 3: Health History & Functional Medicine Overview

### Primary Concerns & Goals

Please describe the top health concerns, symptoms, or goals you would like to address:
_____
_____
_____

### Medical & Surgical History

- Current diagnoses or chronic conditions (include dates of diagnosis if known):
  _____
  _____
- Past surgeries or hospitalizations (include approximate dates):
  _____
  _____
- Do you have a pacemaker, insulin pump, pain pump, or metal implants? Y/N _____ If yes, describe:
  _____
- Female Clients: Pregnant? Y/N _____ If yes, how far along? _____
- Known food or drug allergies/sensitivities:
  _____
  _____
- History of seizures? Y/N _____ If yes, describe:
  _____

## Functional Medicine Context

- Sleep quality (hours/night, interruptions, insomnia, waking refreshed?):
  _____
- Stress level (low/medium/high). What are your main stressors?
  _____
  _____
- Digestive/gut concerns (bloating, constipation, diarrhea, reflux, food intolerances):
  _____
- Detox capacity (sensitivity to chemicals, history of mold, toxin or heavy metal exposure):
  _____
- Energy level throughout the day (morning, afternoon, evening patterns):
  _____
- Emotional history (stress, trauma, grief that may still impact health):
  _____
- Current exercise or movement habits:
  _____
- Nutrition overview (typical daily meals, dietary style):
  _____
  _____
- Additional Information:
  _____
  _____

## Section 4: Current Medications, OTCs, Supplements & Treatments

Please list **everything you currently take or use** (include brand if known). This helps identify potential interactions, nutrient depletions, and opportunities for simplification.

**Tip:** If easier, attach photos of labels or pharmacy printouts along with this form.

### A) Prescription Medications (Rx)

| Name (Brand /Generic) | Strength /Dose | Route | Frequency /Timing | Purpose (Why) | Prescriber | Start Date | Notes (Side effects, effectiveness, missed doses) |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
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### B) Over-the-Counter (OTC) Medications

| Name | Strength /Dose | Route | Frequency/Timing | Purpose (Why) | Start Date | Notes |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

### C) Supplements (vitamins, minerals, herbs, nutraceuticals)

| Product /Brand | Active Ingredients (if known) | Dose (per serving) | Frequency/Timing | Purpose (Why) | Start Date | Notes (tolerance, benefit) |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

| Product /Brand | Active Ingredients (if known) | Dose (per serving) | Frequency/Timing | Purpose (Why) | Start Date | Notes (tolerance, benefit) |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

## D) Current Treatments & Therapies

*(e.g., IV therapy, peptides, BHRT/bioidentical hormones, red-light therapy, sauna, chiropractic, acupuncture, physical therapy, counseling/coaching, massage, ozone, etc.)*

| Treatment /Therapy | Provider /Clinic | Frequency | Start Date | Goal /Purpose | Response so far |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Upload recent lab results (optional):** _____

**Anything else I should know about how you take your meds/supplements (timing with food, caffeine, workouts, sleep)?**

_____

_____

# Section 5: Lifestyle & Environmental Factors

- Caffeine, alcohol, or nicotine use: _____
- Environmental exposures (plastics, chemicals, occupational hazards): _____

  _____
- Current hydration (amount and type of fluids daily): _____
- Support system (family, friends, faith, community): _____

## Section 6: Package Selection

Please select your package:

[ ] **Quick Insight ($75):** Scan + Infoceutical recommendations

[ ] **Deeper Understanding ($300):** Scan + Recommendations + Partial Report

[ ] **Full Restoration Map ($500):** Scan + Recommendations + Full Report + Lifestyle Guidance

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## Section 7: Client Acknowledgement

I confirm that I have provided accurate and complete health history and personal information. I understand the services provided are for educational and wellness purposes only. I release Kelly Brink LLC from liability related to undisclosed health conditions or my independent application of recommendations.

I acknowledge that: - No guarantees have been made regarding outcomes. - Services do not replace licensed medical care. - I remain responsible for seeking medical attention when appropriate.

**Client Printed Name:** _____

**Signature:** _____ **Date:** _____

**Practitioner: Dr. Kelly Brink, PhD, DNM, DHM, RN, CHWC**