Holistic Nutrition and Ayurvedic Medicine
Candice Trudel, MS, HNC, AHC

Name: ____Date of Birth: ____________ Age: ________

Address: ____

City: _________________________ State: ___________ Zip: ____________________________

Phone (h): __________________ (w): ____________________ (c): ____________________________

Email: ____

PC: ____

Height: _______Weight: _______Occupation: ________________________ How long: _____________

Marital/Relationship status: ___________________________# of Children/Dependents: ____________

Name of Emergency contact: ______________________ Relationship to you: _____________________

Phone: ________________________ Or: ____

Please describe your present health concerns and their duration:

What would you like to accomplish on your first visit?

Describe your top 3 stressors:

Medical History

Are you currently under the care of a family physician or other health professionals? If no please explain.

Are you currently taking any medications and/or receiving any medical treatment for your health condition? Please list medications and dosage.

Have you had any of the following in the last five years?

Test	When	For What reason	Results/Outcome
Bone density			
CT Scan			
Colonoscopy			
EEG			
Endoscopy			
MRI			
Ultra Sound			
X-Ray			

Have you had any past hospitalizations? If so, what for and when?

Are you allergic to any substances? Please specify, including foods, pollens, dust, etc. Any other allergic reactions?

Do you have any past medical history? If yes, please specify the age of occurrence, duration and treatment.

Health as a child: ☐ Good ☐ Fair ☐ Poor

Please rate your energy level: ☐ Very high ☐ High ☐ Moderate ☐ Low ☐ Very Low

What time of day do you feel best? ________________________

What time of day do you feel worse? ________________________

Family History

	If living		*If deceased*	
	Age	**Health**	**Age**	**Cause of death**

Mother : ____

Father: ____

Siblings: ____

____

____

Children: ____

____

____

Do you have a family history of any of the following?

Condition	Yes	Family Member(s)	Age of Onset	Description
Heart Disease	☐			
High Blood Pressure	☐			
Stroke	☐			
Diabetes	☐			
Cancer	☐			
Overweight	☐			
Food Intolerance	☐			
Autoimmune Disease	☐			
Asthma/ Hay Fever	☐			
Kidney Disease	☐			
Osteoporosis	☐			
Suicide	☐			
Thyroid Disease	☐			
Tuberculosis	☐			

Nutrition History

Have you changed your eating habits for a health reason?

Do you avoid any particular foods?

Are you currently following a particular diet or nutrition plan? If yes, please explain

Have you recently lost or gained weight? Yes No If yes, please describe.

Do you have or have you had an eating disorder? Yes No If yes, please describe.

How many meals do you eat each day?	How many snacks do you eat each day?
How many meals do you buy from a restaurant or fast food **per week?** 0-1 2-3 4-6 > 6	
Do you drink alcohol? Yes No If yes, how many drinks **per week?**	
Do you drink caffeinated beverages? Yes No If yes, how many cups **per day?**	
Do you use any natural or artificial sweeteners? Yes No If yes, which ones?	
What is your favorite meal?	

Check all of the factors that apply to your eating habits and current lifestyle:

- ☐ Love to eat
- ☐ Love to cook
- ☐ Emotional eater
- ☐ Late night eater
- ☐ Struggle with eating issues
- ☐ Family members have different tastes
- ☐ Dislike cooking
- ☐ Fast eater
- ☐ Erratic eating patterns
- ☐ Eat too much
- ☐ Rely on convenience foods
- ☐ Eat fast food frequently
- ☐ Make poor snack choices
- ☐ Confused about food/nutrition
- ☐ Live alone or eat alone often
- ☐ Do not plan meals or menus
- ☐ Time constraints
- ☐ Travel frequently
- ☐ Eat only because I have to
- ☐ Negative relationship with food
- ☐ Dislike healthy food
- ☐ Don't know how to cook

Do you eat between meals: ☐ yes ☐ no

Do you eat your meals at the same time each day: ☐ yes ☐ no

Which is your main meal? ☐ Breakfast ☐ Lunch ☐ Dinner

Rate your digestion: ☐ Good ☐ Fair ☐ Poor

How much water do you drink per day? ☐ Never ☐ 1-2 glasses ☐ 3-4 glasses ☐ 5-6 glasses ☐ 7+

My eating habits include: ☐ Eat w full attention on food ☐ Talk while eating ☐ Eat fast
☐ Watch television while eating ☐ Eat while reading/working ☐ Eat on the go

What tastes do you like or crave? ☐ Sweet ☐ Sour ☐ Salty ☐ Hot/Spicy ☐ Bitter ☐ Starches ☐Oily

Are there any particular foods that create discomfort when you eat them? Please list:

Digestion

Do you experience any of the following: ☐ Gas ☐ Bloating ☐ Constipation
☐ Heartburn ☐ Sour burps ☐ Diarrhea
☐ Low appetite ☐ Nausea ☐ Heavy feeling in the stomach

Bowel Movements

☐ Once per week ☐ Once every 2-3 days ☐ Once daily ☐ 2-3 times per day ☐ 4+ times daily
☐ First thing in the morning ☐ Late in daytime ☐ Immediately after meals ☐ Immediately after dinner
☐ Need laxatives daily ☐ Other, please specify:
____

Bowel nature: ☐ Soft ☐ Medium ☐ Hard

Are your bowel movements associated with: ☐ Pain ☐ Gas ☐ Blood ☐ Mucous ☐ Foul Smell
☐ Other, please specify: ____

Urination

Do you experience any of the following: ☐ Pain ☐ Burning sensation ☐ Discoloration
☐ Frequent urination during the day ☐ Urination several times during the night
☐ Other, please specify: ______________________

Natural Urges

Do you delay or suppress any of the following: ☐ Bowel movements ☐ Gas ☐ Urination
☐ Sleep ☐ Yawning ☐ Burping ☐ Breathing ☐ Sneezing ☐ Hunger ☐ Semen ☐ Tears

Emotions

What is your present state of mind and emotions? ☐ Good ☐ Fair ☐ Poor

Do you often experience any of the following? ☐ Worry ☐ Depression ☐ Lack of energy
☐ Anxiety ☐ High stress levels ☐ Fear or Panic ☐ Lack of memory
☐ Anger ☐ Irritation ☐ Loneliness ☐ Light headedness

How are your family relationships? ☐ Good ☐ Fair ☐ Poor

How is your social life? ☐ Good ☐ Fair ☐ Poor

How is your mental state? ☐ Good ☐ Fair ☐ Poor

How is your career? ☐ Love it ☐ Like it ☐ Unhappy with it

How purposeful is your life? ☐ Completely ☐ Neutral ☐ Not happy

Rate your spiritual life: ☐ Satisfying ☐ Neutral ☐ Empty

Daily Routine

How regular is your daily routine? ☐ Very regular ☐ Somewhat regular ☐ Irregular

Do you practice any type of meditation? Please explain.

Do you practice any type of yoga? Please explain.

Do you travel a lot? ☐ yes ☐ no

How often do you smoke cigarettes?
☐ Never ☐ less than once per week ☐ several times a week ☐ more than once per day || How many: _____

Which type of weather makes you feel most uncomfortable? ☐ Cold ☐ Hot ☐ Cold and damp

How often do you exercise?
☐ Never ☐ Weekly once ☐ Weekly twice ☐ 3-4 days weekly ☐ 5-6 days weekly ☐ daily

How long do you exercise? _______________________ What type of exercise? ____________________________

Is your exercise: ☐ Vigorous ☐ Moderate ☐ Light or Gentle

What is your body build? ☐ Thin ☐ Large ☐ Average ☐ Muscular
Are you overweight? ☐ yes ☐ no
If yes, by how much? ☐ Less than 15 lbs ☐ 15-30 lbs ☐ 30-50 lbs ☐ More than 50 lbs

Are you underweight? ☐ yes ☐ no
If yes, by how much? ☐ Less than 10 lbs ☐ 10-20 lbs ☐ More than 20 lbs

What time do you wake up? _______________

What time do you go to bed? ______________

Do you sleep in the daytime? ☐ yes ☐ no

How do you generally feel on arising in the morning? ☐ Fresh & rested ☐ Little tired
☐ Very tired

How is your sleep? ☐ Sound, normal duration ☐ Light, interrupted
☐ Too heavy and too long ☐ Difficulty falling asleep ☐ Difficulty waking up
☐ Awaken too early ☐ Too little sleep ☐ Frequent Nightmares

Do you experience pain during intercourse? ☐ yes ☐ no

Do you have any sexual difficulties? ☐ yes ☐ no
If yes, please explain:

~For Women:

Age menses began: _________________ years

Which of the following describes your menstruation: ☐ Regular ☐ Irregular ☐ Too frequent ☐ Absent
☐ Ceased due to menopause

How many days does your menstrual period last? ☐ 0-4 days ☐ 5-7 days ☐ +7 days
☐ Spotty irregularity throughout the month ☐ Other, please specify: ______________________

How is your menstrual flow? ☐ Heavy ☐ Light ☐ Normal

Associated symptoms (before or during menstruation): ☐ Food cravings ☐ Cramping
☐ Fluid Retention ☐ Migraine ☐ Depression ☐ Breast tenderness ☐ Nightmares
☐ Acne ☐ Tension ☐ Anger ☐ Frustration ☐ Other

Are you pregnant now? ☐ yes ☐ no ☐ don't know

Do you take contraceptive pills or devices? ☐ yes ☐ no If yes, please explain:
____

Number of previous pregnancies: __________________

How many children do you have? __________________ Children's ages:
____

Do you self-examine your breasts regularly? ☐ yes ☐ no
Do you experience any problems in your breasts? ☐ Lumps ☐ Pain or tenderness ☐ Nipple discharge
☐ Other, please explain:

Consent Form

Please read the following document carefully. If you have questions, please ask before signing it. Candice Trudel MS, HNC, AHC wishes to provide you with the highest quality health care possible, and in order to do so, it is necessary that you understand the following.

Consent to Treatment: Treatment at this practice requires an agreement between you the patient, and the practitioner. Any therapy will proceed by mutual consent between the practitioner and you, the patient. You agree to discuss any problems with the practitioner so that they may have a clear picture of your health at the time of service. If you refuse to sign, treatment will be denied.

Holistic medicine: Because of the possibility of drug interaction with herbs and nutritional supplements, we require our patients to inform your practitioner of any medications they may be taking, including any dietary supplements and herbs. **Patients must inform the practitioners of any possibilities of pregnancy.**

Lateness and billing policies:

- Respect your practitioner and the patients who are scheduled after you, and arrive on time for your appointment. You will be charged the full fee, even if you arrived late. The practitioner is waiting for you! We will not be able to make up the lost time. If you are more than 15 minutes late, your appointment will be rescheduled and you will still be charged for the appointment you were late for.
- We are not billing insurance companies at this time, so full payment is needed at time of service and your invoice can be coded for you to submit for reimbursement from your insurance company.
- Please make note of the date and time of your upcoming appointment. **No Shows will be charged the full appointment fee for the missed visit.**

Cancellation Policy: This office requires at least 24 hours notice of cancellation in advance of the scheduled appointment with Candice Trudel. You will be charged half the appointment fee the first time, and the full appointment fee any subsequent short notice missed visits. You must pay this fee out of pocket. YOUR SAFETY IS IMPORTANT TO US, SO INCLEMENT WEATHER CANCELLATIONS WILL NOT BE CHARGED.

I HEREBY,

- CERTIFY THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICE RENDERED TO ME/ SUPPLEMENTS SOLD TO ME. I WILL PAY IN FULL FOR ALL NOT REIMBURSED BY INSURANCE.
- I CERTIFY THAT I AM RESPONSIBLE FOR ANY MISSED APPOINTMENT FEES DUE TO NOT CANCELLING IN THE STATED TIME PERIOD.
- I CERTIFY THAT I HAVE READ ALL THE ABOVE PATIENT POLICIES CAREFULLY

Signed:____Print:____________________Date:___________