FEEL WELL:

Nutrition Counseling

at Middlesex YMCA

Client Registration Packet

Please return packet to the welcome center and our nutritionist will contact you to schedule an appointment.

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| Contact INFORMATION | | | | | | | | | | | |
| Last name: | | | First: | | | MI: | | | | Birth date (MM/DD/YYYY): | |
|  | | | | | | | | | |
| Street address: | | | | | | | | | City: | | |
|  | | | | | | | | |  | | |
| State: | ZIP Code: | Phone (home): | | | | | | | | Phone (cell): | |
| Email: | | | | | | | | May we send you emails? ❑ Yes ❑ No  May we call you and leave a message?  ❑ Yes ❑ No | | | |
| Referred by (please check all that apply):  ❑ Self ❑ Friend ❑ Family ❑ YMCA member ❑ YMCA employee:  ❑ Doctor ❑ Hospital ❑ Other: | | | | | | | | | | | |
| IN CASE OF EMERGENCY | | | | | | | | | | | |
| Please contact, Name: | | | | | Relationship to client:: | | | | | | Home phone: |
| Cell phone: | | | | | Work phone: | | | | | |
|  | | | | |  | | | | | |
|  | | | | | | | | | | | |
| Health INFORMATION | | | | | | | | | | | |
| Height  Feet: Inches: | | | | Weight (lbs): | | |
| Do you have, or have you had in the past, any of the following (check all that apply):  ❏Type 1 Diabetes ❏Type 2 Diabetes  ❏ Prediabetes ❏Gestational Diabetes  ❏ Kidney Disease ❏ Eating Disorder  ❏Heart Disease (CAD/CVD) ❏Vascular Disease  ❏ Heart Failure (CHF) ❏ Osteoporosis ❏ Anemia ❏ Hypertension ❏ High Cholesterol ❏ Hypo/Hyperthyroidism ❏ Endocrine Disorder ❏ Bariatric Surgery ❏ Bowel Resection ❏ Diverticulosis/itis  ❏ Irritable Bowel Syndrome (IBS/IBD)  ❏ Digestive Disorders (e.g. Crohns, Malabsorption, Celiac Disease)  ❏other: | | | | | | | Do you have a family history of any of the following?  ❏Type 1 Diabetes ❏Type 2 Diabetes  ❏ Prediabetes ❏Gestational Diabetes  ❏ Kidney Disease ❏ Eating Disorder  ❏Heart Disease (CAD/CVD)  ❏Vascular Disease ❏ Heart Failure (CHF)  ❏ Osteoporosis ❏ Anemia ❏ Hypertension  ❏ High Cholesterol ❏ Hypo/Hyperthyroidism  ❏ Endocrine Disorder ❏ Bariatric Surgery  ❏ Bowel Resection ❏ Diverticulosis/itis  ❏ Irritable Bowel Syndrome (IBS/IBD)  ❏ Digestive Disorders (e.g. Crohns, Malabsorption, Celiac Disease) | | | | |
| ❏other: | | | | |
| Are you currently prescribed and/or taking any of the following medications?  ❏ Diuretic (also known as a “water pill”)  ❏ Antihypertensive or ACE inhibitor  ❏ Anticonvulsant (phenobarbitol)  ❏ Anticoagulant (warfarin, coumadin)  ❏ Corticosteroid (prednisone, cortisone)  ❏ Cholesterol lowering drugs  ❏ Antacid ❏ Digestive enzymes  ❏other medications: | | | | | | | Please specify any diet or diet restrictions currently prescribed by your physician: | | | | |
| Do you currently take any nutrition supplements (multivitamin, oral minerals, etc.) or use alternative medicines (essential oils, herbs, etc)? ❑ Yes ❑ No  If yes, please list: | | | | | | | | | | | |
| Do you have any specific questions or concerns? Please describe. | | | | | | | | | | | |

Staff Use

Received by nutritionist:

Date of first evaluation: