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 ❑ NoMay 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 |
| HeightFeet: 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: