FOR OFFICE USE ONLY:
Date Paperwork Received: __________________

Receipt #: __________________

# of Consultations Purchased: __________________

Fitness/Wellness Program
(PLEASE WRITE LEGIBLY!)

Nutrition Consultation

Date: __________________ (Sessions expire August 31st of each fiscal year)

Name: ____
Last First MI

Age: __________________ EID: __________________

Address: ____

City: __________________ State: ________ Zip: __________________

Phone: (H) __________________ (M) __________________ (W) __________________

Email: ____

Emergency Contact Information

Name: ____

Phone: __________________ Relationship: __________________

When are you available to meet with the Dietician? Please list as many times as possible *after 5:30pm* and be specific:

Monday __________________ Thursday __________________

Tuesday __________________ Friday __________________

Wednesday __________________ Saturday __________________

Sunday __________________

Please Note: The Dietician will contact you to set up your meeting times. The location is RSC 1.145 (the PT Studio Office in the Recreational Sports Center).

Health / Medical History Questionnaire

Please complete this section as thoroughly as possible.

Physician's Name: ____

Physician's Phone: ____

Does your physician know you are seeing a Registered Dietitian? ☐ Yes ☐ No

Would your physician like to have the RD send him reports of your progress? ☐ Yes ☐ No

If yes, please specify your reporting needs

____

____

PERSONAL MEDICAL HISTORY

Please check yes or no for the following questions:

Do you now have or have you had in the past:	Yes	No	*If yes, please explain.*
Heart disease or stroke			
Irregular heartbeat			
Defective heart valve(s)			
Angina			
Heart attack (MI)			
Pulmonary disease			
Stroke			
Diabetes			
High cholesterol levels			Last measured level:
Depression			
Fatigue			
Peripheral Vascular Disease			
Hypertension			
Cancer			Specify Type:
Back Pain			
Joint Pain			Specify Type:
Migraines/Headaches			
Asthma			Exercise Induced?: ☐ Yes ☐ No
Lightheadedness/Fainting			
Allergies			
Females only: Is there a possibility that you could be pregnant?			Are you pregnant?: ☐ Yes ☐ No If yes, how many months? _________
Eating disorder			
Auto-Immune Disease (Please write in type)			Examples: Rheumatoid Arthritis, Crohn's disease, Diabetes Type 1, Lupus, Celiac disease. Complete listing available at: http://www.aarda.org/research_display.php?ID=4
Food allergies/ Intolerances (please list)			
Inflammatory Bowel Disease			Specify Type:

FAMILY MEDICAL HISTORY

Please check yes or no for the following questions:

Is there a history of any of the following in your immediate family?	Yes	No	*If yes, please explain.*
Heart attack prior to the age of 50?			Who?
Heart disease prior to the age of 50?			Who?
Diabetes			
High Cholesterol			
Hypertension			
Stroke			

Please list any surgeries you have had and the approximate date of each:

_______________________________________ Date: _____________

_______________________________________ Date: _____________

_______________________________________ Date: _____________

_______________________________________ Date: _____________

_______________________________________ Date: _____________

Please list your current MEDICATIONS AND/OR NUTRITIONAL SUPPLEMENTS you are currently taking.

Medication/Supplement Name	Reason taken	Prescribed/Recommended by

Do you currently smoke cigars/cigarettes/pipes? ☐ Yes ☐ No

If yes, how many per day? cigarettes: _________

cigars: _________

pipes: _________

Did you ever smoke cigars/cigarettes/pipes? ☐ Yes ☐ No

If yes, how many per day? cigarettes: _________

cigars: _________

pipes: _________

How long ago did you quit? _________

Please place a check mark next to the most appropriate description of the amount of stress you feel each day.

- ☐ No Stress
- ☐ Occasional Mild Stress
- ☐ Frequent Moderate Stress
- ☐ Frequent High Stress
- ☐ Constant High Stress

Notice Concerning Your Information:
The Texas Public Information Act, with a few exceptions, gives you the right to be informed about the information that The University of Texas at Austin collects about you. It also gives you the right to request a copy of that information; and to have The University correct any of that information that is wrong. You may request to receive and review any of that information, or request corrections to it, by contacting the University's Public Information Officer, Office of Financial Affairs, PO Box 8179, Austin, Texas, 78713 (email: cfo@www.utexas.edu)

Registered Dietitian Policy Review & Checklist

Through your assistance in understanding and adhering to the policies established, UT RecSports can continually provide an inspiring, safe and educational environment for the diverse population it serves.

By initialing next to each directive below and signing this policy review & checklist, you are indicating that you have read, understood and will abide by the policies stated.

Initial:

___________ **Gregory Programs Office Operational Hours**
The Gregory Gym Programs office is available to assist in answering questions and facilitating registration. Business hours are: Monday - Friday, 8am - 5pm.

___________ **Identification**
Gregory Gym and all other RecSports facilities are controlled access facilities. Identification must be presented at the front desk to gain access to the buildings. If you are a non-member signing up for Dietitian appts, the Dietitian will meet you with your guest pass and you will sign in at the front desk as a guest.

___________ **Refund Policy**
An individual registering for Nutritional Consultation agrees to complete all sessions by the end of the client's eligibility, or by the end of the fiscal year (8/31 of each year). All sessions not accounted for will be forfeited. A partial refund may be approved at the discretion of the Assistant Director if: 1) the individual has a change in health status accompanied by confirmation from a medical professional. 2) The individual's eligibility to participate unexpectedly changes (ie- membership expires). In the case of all refunds, a $10.00 processing fee may be assessed.

___________ **Transfer Policy**
All Nutritional Consultation sessions are non-transferable.

___________ **Late Policy**
Registered Dietitian clients are responsible for arriving in a timely manner to their sessions. The Dietitian is required by policy to wait 10 minutes beyond the scheduled start time before the session is considered forfeited. If a client's session begins late due to the client's late arrival, the trainer reserves the right to deduct those minutes from the session.

___________ **Cancellation Policy**
Except in the event of an emergency, a minimum of 24 hours notice is required for the cancellation of a nutrition consultation session. Clients will be charged for sessions cancelled with less than 24 hours notice. Registered Dietitian clients should contact the Dietitian directly should they need to cancel. If a client is unable to reach the Dietitian, they may contact the Programs Office at 471-3116 (during business hours).

___________ **Health Status**
In the event that the status of your health changes, it is your responsibility to notify the Dietitian and update your paperwork on file in the GRE Programs Office. Certain medical conditions, for your safety and wellbeing, may require a modification to your nutritional habits.

___________ **Expiration of Sessions with the Registered Dietitian**
All sessions expire August 31st of each year.

I have read and understand the policies and procedures stated above.

______________________________	______________________________	____________________
Signature of Participant	Printed Name of Participant	Date Signed

Exercise and Nutrition Habits Questionnaire

Please take the time to complete this questionnaire to maximize your session time with the Dietitian. These questions assist the Dietitian in tailoring your consultations to meet your needs.

Do you exercise most days of the week?

- ☐ No, but I would like to in the near future.
- ☐ Not consistently, but I intend to in the next 30 days.
- ☐ Yes, I have been for less than 6 months
- ☐ Yes, I have been for more than 6 months.

Do you currently exercise? ☐ Yes ☐ No

How often? ☐ <1 x per month ☐ 1-2 x per week ☐ 3-5 x per week ☐ 6 or more x per week

How long? ☐ 10-20 minutes ☐ 20-30 minutes ☐ 30-40 minutes ☐ 45+ minutes

What intensity? ☐ light ☐ moderate ☐ vigorous

How much time are you realistically willing and able to dedicate to an exercise program?

__________ Minutes/Day ____________ Days/Week

What type of activities to you do when you exercise (Please list in the space below.)?

MEAL PLANNING

Who typically plans your meals?	☐ Self ☐ Spouse ☐ Meal plan/food service at dorm	☐ Roommate ☐ Family ☐ Eat out mostly
Who typically grocery shops in your household?	☐ Self ☐ Spouse ☐ Meal plan/food service at dorm	☐ Roommate ☐ Family ☐ Eat out mostly
Who cooks in your household?	☐ Self ☐ Spouse ☐ Meal plan/food service at dorm	☐ Roommate ☐ Family ☐ Eat out mostly

Please indicate the *number* of meals that you Dine out each week (most people eat 4 meals per day, 7 days per week to total 28) :
_______________ meals/wk

How often do you eat out at the following places.
Please circle the number corresponding to the answer that best describes your habits.

1 = Seldom (0-1 per month or less)
2 = Weekly (0-2 times per week)
3 = Regularly (3-5 times per week)
4 = Often (6-10 times per week)
5 = Daily (11-28 times per week)

Fast food restaurants	1	2	3	4	5
Other restaurants	1	2	3	4	5
Other people's homes	1	2	3	4	5
Residential dining hall	1	2	3	4	5

Beverages

Please indicate how often you drink the following beverages. Please indicate the number of times per week or per day, as specified.

	Number of Times	Per (circle one)
Water		Day
Coffee		Day
Soda		Day / Week
Tea		Day / Week
Alcoholic Beverages		Week
Energy Drinks		Week

FOOD HABITS

What would you say are your "worst food habits" (Please list in the space below):

How often do you consume each of the following.

Please circle the number corresponding to the answer that best describes your habits.

1 = Seldom (0-1 per month or less)
2 = Weekly (0-2 times per week)
3 = Regularly (3-5 times per week)
4 = Often (6-10 times per week)
5 = Daily (11-28 times per week)

Fruits (apples, oranges, etc.)	1	2	3	4	5
Fruit Juices (100% juice only)	1	2	3	4	5
Vegetables (include veggies and vegetable juice here)	1	2	3	4	5
Legumes (Black beans, refried beans, soy products, peanuts, lentils)	1	2	3	4	5
Dairy Products (yogurt, milk, cheese)	1	2	3	4	5
Meats (chicken, beef, pork)	1	2	3	4	5
Seafood (fish, shellfish, salmon)	1	2	3	4	5
Sweets	1	2	3	4	5
Added Fats (oils, butter, etc.)	1	2	3	4	5

HEALTH HABITS

(Please circle one answer.)

In general, your health is: Poor Fair Good Very Good Excellent

REASON FOR VISIT

(Please circle at least one answer.)

Weight Loss
Weight Gain
Vegetarian Diet
Sports Nutrition
Hypertension
Diabetes
Other (Please describe.) :

WEIGHT LOSS (IF REASON)

Have you tried to lose weight in the past? YES NO
Were you successful? YES NO
Please list the method/ diet plan you used: ______________________________

What is your healthiest weight (in your opinion)?

What is your Current Weight?

What is your Current height?