



Youngstown State University

Client Questionnaire

General Information

Full Name: _____ Date: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Phone: () - E-mail Address: _____

Banner #: _____

Please check all that applies:

____ Resident (or) ____ Non-resident

____ Male (or) ____ Female

Athlete? ____ Yes ____ No

Pregnant? ____ Yes ____ No

Nursing? ____ Yes ____ No

Body Type Information (Staff is available to take BMI, Body Fat %, & Waist to Hip Ratio)

Height: _____ ft. _____ in. Body Build: ____ Small ____ Medium ____ Large

Present Weight: _____ Desired Weight: _____ Desired Weight Loss or Gain per Week: _____

How long have you been at your present weight? _____

Activity Level: ____ Sedentary ____ Moderately Active ____ Very Active

Present % Body Fat: _____ Desired % Body Fat: _____

BMI: _____ Waist to Hip Ratio: _____

Questions

Weekly exercise regimen, if any (describe): _____

Foods you like (or wish to emphasize): _____

Foods you dislike (or need to avoid): _____

Do you have any food allergies, if yes please list: _____

How often do you eat on campus (Christman Dining, KC Café, etc)? _____

How often do you eat out (fast food and restaurants)? _____

What restaurants do you eat at and how often? _____

What beverage do you drink most often? _____

Nutrients (if any) that you are attempting to control: _____

Why do you wish to see a Nutritionist and what are your nutritional goals? _____

Smoke: _____ Yes _____ No

How many alcoholic drinks do you normally consume in one week: _____

Are you currently taking any medications, if yes please list: _____

Are you currently taking any vitamins/supplements, if yes please list: _____

Are you following any special diets currently or have you recently? If yes, please explain. _____

Have you every tried using medication to lose weight? _____ Yes _____ No

Medical Conditions/Concerns: _____

Family Medical History (i.e.: heart disease, hypertension, etc): _____

When did you last visit your physician? _____

Has your physician recommended that you follow any type of diet? _____

Is your physician aware of your nutritional goals? Does he/she agree with these goals? _____

Do you exercise? If yes, how often and what type of exercise? _____

Has your physician given you clearance to participate in exercise? _____

Would you like information on starting an exercise program? _____ Yes _____ No

Exercise limitations: _____

Comments and concerns: _____



Informed Consent

I understand that the nutrition counseling provided is not medical treatment or substitute for any treatment. I have provided truthful personal medical data and am seeking nutritional counseling with the approval of my physician. I understand nutrition counseling is voluntary and that I may discontinue participation at any time without penalty or prejudice toward me.

By signing my name below, I further certify that I have read and understood the terms and conditions of this agreement and intend to legally be bound by it.

Signature _____ Date _____

Release of Information

I authorize the release of my pertinent health/nutrition/fitness information between the Registered Licensed Dietician and Personal Training/Fitness Assessment staff for the purpose of developing a comprehensive nutrition and fitness plan.

Signature _____ Date _____

Print Name _____



Nutrition Par-Q

It is the aim of the Department of Campus Recreation and Intramural Sports to give you, the Patron, the best services that we can. Please help us by filling out this questionnaire so we may fulfill your expectations of a successful nutrition assessment/session. If you answer 'yes' to any of these questions, we ask that you consult your Physician for clearance.

Yes _____ No _____

1. Have you been diagnosed with a chronic medical condition/disorder requiring the care of a physician and/or are you currently experiencing any unresolved medical issues?

Yes _____ No _____

2. Do you require routine prescription medication other than those related to asthma, seasonal allergies, or birth control?

Yes _____ No _____

3. Has a physician ever diagnosed or treated you for an eating disorder?

Decline _____ Accept _____

I accept responsibility for my appointment. If I do not cancel at least 24 hours prior to my appointment or I do not show up, I understand that I can not make a new appointment until the next semester.

Student Name _____ Phone _____

Signature _____ Date _____