NUTRITION COUNSELING
CLIENT INFORMATION

WELCOME TO CLEVELAND STATE UNIVERSITY'S CAMPUS RECREATION CENTER!

Thank you for your interest in our Nutrition Counseling program. We want to help you reach your health and fitness goals by pairing you up with our Registered Dietitian. Before you begin your program, please take a moment to fill out the following information.

Please review the member policies and Procedures Manual for all inquiries concerning the Nutrition Counseling program.

This packet includes the following:

- Nutrition Client Questionnaire

All information submitted in this packet will be kept confidential. Client information regarding health history in any form may only be accessed by appropriate staff of Cleveland State University Campus Recreation. Appropriate staff may include, but is not limited to, the Registered Dietitian, Fitness & Wellness Coordinator and Associate Director of Programs.

SHOULD YOU HAVE ANY FURTHER QUESTIONS, PLEASE CONTACT CAMPUS RECREATION SERVICES

216.802.3256

CSU
CAMPUS RECREATION SERVICES

NUTRITION CLIENT QUESTIONNAIRE

Date: ______________________________

First Name: ______________________________ Last Name: ______________________________

Occupation: ______________________________ Student: Yes No

Gender: Female Male Age: ______________________________

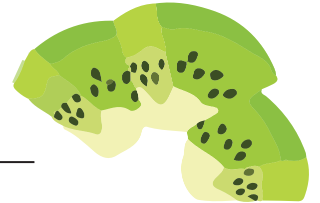
Height: ________ ft. ________ in. Weight: ______________________________

Member at CSU Recreation Center: Yes No

*Please list three days and time frames that you would be available for a nutrition consultation:

1. Day: ______________________________ Time: ______________________________
2. Day: ______________________________ Time: ______________________________
3. Day: ______________________________ Time: ______________________________

**Please be aware that while we will make every effort to accommodate the provided times, we cannot guarantee that a dietician will be available to meet your exact schedule. Thank you in advance for your understanding.



Medical Conditions/Concerns:

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____

Current exercise regimen (Describe):

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Nutrition goals:

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

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

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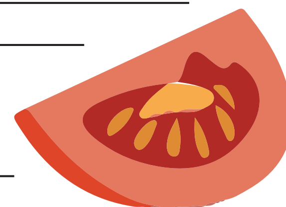

Would you like information on starting an exercise program? Yes No

Additional Comments/Information for the Dietitian:

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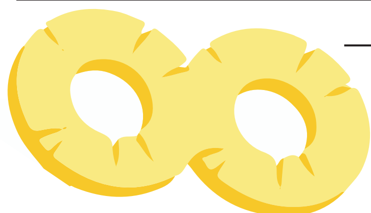

INFORMED CONSENT

I understand that 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:____