



### Welcome to Nutrition Services at CRI

Thank you for making a commitment to your health and wellness through CRI and the Nutrition Services program. Turn this application in along with the completed three day dietary record, the nutrition questionnaire and your payment into the CRI main office(Member Services) on the first floor of the RAC to schedule a session. On the three day dietary record, record everything you eat and drink throughout the day for three days. Return all three forms in to schedule your appt.

### Nutrition Services Application and Intake Form

Name: \_\_\_\_\_ Eagle ID: \_\_\_\_\_

Gender: \_\_Male \_\_Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Activity Level: High Moderate Low Daily  
Activities: \_\_\_\_\_

Campus Affiliation:  Faculty  Staff  Student: Expected Graduation \_\_\_\_\_

E-mail: (please print legibly) \_\_\_\_\_

Phone#: \_\_\_\_\_

Local Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

In case of Emergency, Please notify:

\_\_\_\_\_

Telephone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Do you have any medical conditions, food allergies, or diet preferences that the dietician should be aware of? Please include more information on the back of this page if needed.**  
Ex. Diabetes, Vegetarian, allergic to soy, etc.

\_\_\_\_\_

For Office Use Only:

Amount Paid: \_\_\_\_\_

Receipt # \_\_\_\_\_

Initials: \_\_\_\_\_

Date Received: \_\_\_\_\_



# Welcome to Nutrition Services at CRI

## Nutrition Questionnaire

Date: \_\_\_\_\_ Name: \_\_\_\_\_  
Last First (legal) Preferred First

Phone: ( ) \_\_\_\_\_ Can we leave a message at this number to remind you of your appointment day and time?  Y  N

Class/Major: \_\_\_\_\_ ID#: \_\_\_\_\_

Where do you live:  on-campus  off-campus Age: \_\_\_\_\_ Gender:  Male  Female

Referred by:  Self  Rec Center  Health care provider . . . Name? \_\_\_\_\_

Have you seen a nutritionist before?  Y  N If so, who and when? \_\_\_\_\_

Why do you want to see a nutritionist? (Check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> General healthy eating advice | <input type="checkbox"/> Vegetarian eating   | <input type="checkbox"/> Irritable Bowel Syndrome   |
| <input type="checkbox"/> Want to lose weight           | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Disordered eating concerns |
| <input type="checkbox"/> Want to gain weight           | <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Diabetes                   |

Other (please explain): \_\_\_\_\_

Height: \_\_\_\_\_ Current weight: \_\_\_\_\_ Desired Weight: \_\_\_\_\_

Lowest adult weight: \_\_\_\_\_ Highest adult weight: \_\_\_\_\_

Does your food or weight feel out of control?..  Y  N

Are you currently being treated for a medical condition?.....  Y  N List: \_\_\_\_\_

Are you taking any medications? .....  Y  N List: \_\_\_\_\_

Are you taking any vitamin, herbal, or nutritional supplements? .....  Y  N List: \_\_\_\_\_

Do you have any family history of diabetes, high blood pressure, high cholesterol?.....  Y  N Which? \_\_\_\_\_

Do you drink alcoholic beverages?  Y  N Describe use: \_\_\_\_\_

Are you currently on a special diet? (i.e., vegetarian, low-carb, gluten-free, etc).....  Y  N Describe: \_\_\_\_\_

Where do you eat most often?  Campus  Home  Restaurant Other: \_\_\_\_\_

List any exercise/activity that you do on a regular basis:

<u>Type of exercise/activity</u>	<u>Days per week</u>	<u>Time spent doing that activity (each time)</u>
----------------------------------	----------------------	---

OVER →

Describe changes, if any, that you have made to your eating and/or exercise habits. When did you implement these changes?

What do you hope to achieve as a result of nutrition counseling?

Rate how important this change is to you (0 not at all, 10 extremely) 0 1 2 3 4 5 6 7 8 9 10

Rate how confident you are to make this change at this time 0 1 2 3 4 5 6 7 8 9 10

What barriers, if any, stand in the way of you achieving your nutritional goals?

\_\_\_\_\_  
Student Signature Date

---

**Nutritionist's Notes:**

Plan:

- |   |   |
|---|---|
| <input type="checkbox"/> Student to call for follow-up prn.       | <input type="checkbox"/> Complete Food Journal for min of ____ days |
| <input type="checkbox"/> Student to reschedule in ____ week(s).   | <input type="checkbox"/> Complete hunger/satiety scale.             |
| <input type="checkbox"/> Reschedule now for appt in ____ week(s). | <input type="checkbox"/> Handout given: _____                       |
| <input type="checkbox"/> Return for Eating Issues assessment.     | <input type="checkbox"/> Meal Plan: _____                           |
| <input type="checkbox"/> Refer to physician.                      | <input type="checkbox"/> _____                                      |
| <input type="checkbox"/> Refer to mental health.                  | <input type="checkbox"/> _____                                      |

Dietitian Signature \_\_\_\_\_ Date \_\_\_\_\_

**For office use:** Appt: \_\_\_\_/\_\_\_\_/\_\_\_\_ RD: \_\_\_\_\_

