



**FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY**

## **NUTRITION COACHING AT MCGAW YMCA**

Welcome to Nutrition Coaching at the McGaw YMCA! Our Registered Dietitian looks forward to working with you and helping you meet your healthy living goals.

There are a few steps you must complete in order to begin training:

1. Complete and return the Nutrition Coaching Packet (attached).
2. When we receive your packet, you will receive a phone call or email within a week to schedule your initial consultation. The consultation is a time to talk with your Nutrition Coach, review your paperwork and set goals.
3. Follow-up sessions (if applicable) may be scheduled with your Nutrition Coach at that time or through YMCA staff after your consultation and at your coach's recommendation in duration and frequency.

If you have any questions, please contact:

Alyson Mann  
Health & Wellness Manager  
847-475-7400 ext. 232  
AlysonM@mcgawymca.org

Name: \_\_\_\_\_

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



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## NUTRITION COACH INTEREST FORM

Name: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Best method to contact you:  Cell Phone  Home Phone  Email

Best time to contact you: \_\_\_\_\_

Who referred you to Nutrition Coaching?

Member: \_\_\_\_\_

Personal Trainer: \_\_\_\_\_

Other Staff: \_\_\_\_\_

Other Source: \_\_\_\_\_

When would you like to meet with a Nutrition Coach (mark preferred days/times)?

Sun.  Mon.  Tues.  Wed.  Thurs.  Fri.  Sat.

Early morning (6:00am – 9:00am)  Late morning (9:00am – 12:00pm)

Afternoon (12:00pm – 5:00pm)  Evening (5:00pm – 8:00pm)

Specific time available: \_\_\_\_\_



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The goal of this form is to get you thinking about your nutritional behaviors. It will allow me, as your Nutrition Coach, to gain more insight into how you currently view and approach your health and wellness, as it relates to nutrition. It will assess different facets of your life including energy levels, stress management, current exercise, and diet habits and health history. In order to make positive lasting change, it is important to understand where we are now to continually assess our progress. Thank you for your cooperation!

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Gender identity: \_\_\_\_\_

Pronouns: \_\_\_\_\_

## GOAL SETTING INFORMATION

1. What is your healthy living goal? \_\_\_\_\_

2. What made you decide to start working with a Nutrition Coach now? \_\_\_\_\_

## NUTRITION

1. What are your dietary goals? \_\_\_\_\_

2. What would you like to change about your diet? \_\_\_\_\_

3. Have you ever followed a modified diet? If yes, describe. \_\_\_\_\_

4. Are you currently following a specialized eating plan (e.g. low-sodium or low-fat)? \_\_\_\_\_  
If yes, what type of eating plan? \_\_\_\_\_

5. Why did you choose this eating plan? Was the eating plan prescribed by a physician?  
How long have you been on the eating plan? \_\_\_\_\_

6. Have you ever met with a registered dietician or attended diabetes education classes? \_\_\_\_\_  
If no, are you interested in doing so? \_\_\_\_\_

7. What do you consider to be the major issues with your nutritional choices or eating plan?  
(e.g., eating late at night, snacking on high-fat foods, skipping meals, or lack of variety)



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## NUTRITION

(continued)

8. How many 8oz glasses of water do you drink per day? \_\_\_\_\_
9. What do you drink other than water? List what and how much per day. \_\_\_\_\_  
\_\_\_\_\_
10. Do you have any food allergies or intolerance? If yes what? \_\_\_\_\_  
\_\_\_\_\_
11. Who shops for and prepares your food (circle)? Self Spouse Parent Minimal Preparation
12. How many times per week do you dine out? \_\_\_\_\_
13. Please specify the type of restaurants for each meal: Breakfast, Lunch, Dinner, Snacks  
\_\_\_\_\_
14. Do you crave any foods? If yes, specify: \_\_\_\_\_
15. What does a typical day of eating look like for you?  
Breakfast: \_\_\_\_\_  
Lunch: \_\_\_\_\_  
Dinner: \_\_\_\_\_  
Snacks: \_\_\_\_\_  
Beverages: \_\_\_\_\_

## WEIGHT HISTORY

1. What is your present weight? \_\_\_\_\_ or Do not know      Height: \_\_\_\_\_
2. What would you like to do with your weight (circle one)?  
Lose Weight    Gain Weight    Maintain Weight
3. What was your lowest weight within the past 5 years? \_\_\_\_\_
4. What was your highest weight with the past 5 years? \_\_\_\_\_
5. What do you consider your ideal weight (the sustainable weight at which you feel your best)? \_\_\_\_\_

## OVERALL HEALTH

Typical Blood Pressure (if known)

Systolic (high number): \_\_\_\_\_      Diastolic (low number): \_\_\_\_\_

Are you currently on medication to control blood pressure? \_\_\_\_\_

Blood Lipids (if known)

Cholesterol: \_\_\_\_\_      HDL: \_\_\_\_\_      LDL: \_\_\_\_\_      Triglycerides: \_\_\_\_\_

Are you currently on medication to control any of these? \_\_\_\_\_



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## OVERALL HEALTH

(continued)

### Personal Health History

I am diagnosed with the following health conditions: Circle all that apply

Asthma or alternative Lung Disease

Diabetes

Inflammatory Bowel Disease

Depression/Anxiety

Irritable Bowel Syndrome

High Blood Pressure (140/90 or higher)

Cancer

High Cholesterol (>200)

Heart Disease, Heart failure, Heart Attack

If you circled any of the above, please note if you are taking medication and/or if this health condition is under control.

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**Current Symptoms – I have had the following within the last month:**

**Circle all that apply**

- Chest pain or discomfort, frequent palpitations or fluttering of the heart
- Unusual shortness of breath
- Unexplained dizziness or fainting
- Temporary sensation of numbness or tingling, paralysis, vision problem, or light headedness
- Frequent urination or unusual thirst
- Frequent back pain
- Trouble sleeping

## ENERGY AND STRESS MANAGEMENT

1. What types of exercise do you engage in regularly? (i.e. walking, jogging, weight lifting, yoga)

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2. How many times per week? \_\_\_\_\_

3. Do you have any limitations (injuries, illnesses or medical conditions) that impact your ability to participate in physical activity? \_\_\_\_\_

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## ENERGY AND STRESS MANAGEMENT

(continued)

Energy and Stress Management				
I get a healthy amount of quality sleep.	Often	Sometimes	Rarely	Never
I regularly participate in exercise.	Often	Sometimes	Rarely	Never
I have a healthy relationship with food.	Often	Sometimes	Rarely	Never
I feel as though I am in good physical health.	Often	Sometimes	Rarely	Never
I feel as though I am in a place of good mental health.	Often	Sometimes	Rarely	Never
I feel as though I have healthy family and personal relationships.	Often	Sometimes	Rarely	Never
I feel fulfilled in my career/job.	Often	Sometimes	Rarely	Never
I feel comfortable with my finances.	Often	Sometimes	Rarely	Never
I feel as though I have a healthy level of stress.	Often	Sometimes	Rarely	Never
I take time for self-care, relaxation and fun.	Often	Sometimes	Rarely	Never
My physical or mental health interferes with normal social activities (such as time with family or friends).	Often	Sometimes	Rarely	Never
I maintain a comfortable balance between work, family, friends and personal time.	Often	Sometimes	Rarely	Never
I would like to have more time for (circle as many as you would like)	Work	Family	Friends	Me

Is there anything else you would like to share about your energy and stress management?

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On a scale of 1-10 (1=very unlikely; 10=very likely), what is your level of confidence in your ability to make changes to your nutritional habits? \_\_\_\_\_



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## INFORMED CONSENT

I, (print name), \_\_\_\_\_ acknowledge that I have voluntarily chosen to participate in a Nutrition Coaching program and give consent to YMCA staff to provide nutrition coaching to myself or the listed minor for whom I am a parent/guardian. I acknowledge that YMCA staff are certified in nutrition, and staff are not medical doctors and do not diagnose disease. Any assessment is intended as a guide to developing an appropriate health-supportive program and to monitor progress in achieving goals. I also acknowledge that I have been advised to consult a physician before undergoing any dietary or food supplement changes. I also affirmatively state that I have disclosed any and all known medical conditions, medications I use and any significant personal or family medical history. Medical records and personal information and history shared during nutrition coaching will be kept confidential. Any recommendations that I follow for changes in diet, including but not limited to the use of food supplements, are entirely my choice and my responsibility. I am knowingly assuming any risk associated with nutritional coaching. By signing this document, I assume all risk for my health and well-being and hold harmless of any responsibility the coach/staff and the McGaw YMCA. I understand that questions about diet and nutrition recommendations are encouraged and welcomed.

\_\_\_\_\_  
Participant's Signature (Signature of parent or  
legal guardian if participant is under the age of 18)

\_\_\_\_\_  
Minor's name (printed if applicable)

\_\_\_\_\_  
Date



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## **NUTRITION COACHING POLICIES**

- You must provide a 24-hour notice to your coach to reschedule a session. If you fail to provide adequate notice, please understand that it is the McGaw YMCA's policy that you will be charged for that session.
- All sessions will begin and end on time. Arriving late will result in an abbreviated session.
- All sessions must be pre-purchased. Your coach may no longer meet with you if you have run out of sessions.
- Initial/single consultation expires 30 days from purchase date and is non-refundable and non-transferable.
- All hourly session package purchases (3, 6, and 9) expire 180 days from the date of purchase and are non-refundable and non-transferable.
- If your coach becomes ill, is away for an extended period of time, or leaves the McGaw YMCA, another coach will be assigned to you so that your healthy living progress continues forward. Refunds will not be issued due to a change staff.

I have read and agree to the above policies.

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Signature of Participant

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Date

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(Signature of parent/guardian if Participant is under age 18)

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Date