SHEPHERD UNIVERSITY

Wellness Center

# Nutritional Coaching Packet

# What is Included in a Nutritional Assessment?

The 60-minute Nutritional Assessment is devoted to establishing baseline measurements, analyzing current dietary habits, identifying barriers, and setting behavior-based goals. To maximize the duration of the session, clients will be required to complete and submit the nutritional information packet to the Nutritional Coach, for review, 48-hours before the meeting time. The nutritional information packet is extensive and requires you to track your food intake for three days. The assigned coach will use the client's information to prepare better for the assessment by identifying habits and deficiencies in his or her nutritional intake.

# What is Included in a Coaching Session?

Following the Nutritional Assessment, the coaching sessions will be scheduled on a weekly or bi-weekly basis to provide knowledge and practical application on overcoming personal barriers to health. Sessions are uniquely tailored and include:

- Continual review of dietary logs
- Body Circumference Measurements (dependent on goals)
- Goal specific nutrition education including:
  - hydration, supplementation, portioning, food selection, food timing, meal prepping, macronutrients, calorie balancing, nutrition habits, communicating with your support network, and environment control.

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# Packages and Prices

## Nutritional Coaching Assessment and Session Rates for New Clients:

All clients are required to have a Nutritional Assessment before coaching sessions. Nutrition information packets must be submitted through email or to the Member Services Desk 48-hours before the scheduled assessment.

| | |
|---|---|
| Nutritional Assessment | $120.00 |
| Nutritional Assessment & two (60-minute) Coaching Sessions | $215 |
| Nutritional Assessment & six (60-minute) Coaching Sessions | $385 |

## Nutritional Coaching Session Rates for Existing Clients:

These coaching sessions are only available for clients who have already purchased and completed the Nutritional Assessment.

| | |
|---|---|
| One (60-minute) Session | $65 |
| Two (60-minute) Sessions | $120 |
| Four (60-minute) Sessions | $215 |
| Eight (60-minute) Sessions | $385 |

**For questions and/or additional information, please contact:**

**Jennifer Seeley**

**Group Exercise/ Personal Training and Wellness Coordinator**

**E-mail: jseeley@shepherd.edu**

**Office: 304-876-5050**

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# CONSENT & RELEASE LIABILITY FORM

I understand that the specified staff at the Shepherd University Wellness Center are Certified Nutrition Coaches and do not dispense medical advice nor prescribe treatment. Rather, the coaches provide education to enhance my knowledge of health as it relates to foods, dietary supplements, and behaviors associated with eating. While nutritional and botanical support can be an important complement to my medical care, I understand nutrition coaching is not a substitute for the diagnosis, treatment, or care of disease by a medical provider.

**Initial** __________________

If I am under the care of a healthcare professional or currently use prescription medications, I understand that I should discuss any dietary changes or potential dietary supplements use with my doctor, and should not discontinue any prescription medications without first consulting him or her.

**Initial** __________________

I acknowledge that the care that I receive during my nutritional coaching sessions is separate from the care that I receive from any medical facility. The nutrition coaching sessions are in no way intended to be construed as medical advice or care. I understand that I should continue regular medical supervision and care by my primary care physician.

**Initial** __________________

I understand that I am assuming the risks of my nutrition coaching sessions, including the risks of trying new foods, and the risks inherent in making lifestyle changes.

**Initial** __________________

I understand that the Nutrition Coach will keep my information private, and will not share my information to any third party unless compelled to by law or with my consent.

**Initial** __________________

I understand that all payments must be made in advance for all services. Payment must be made by cash, credit, or check at the Member Services Desk.

**Initial** __________________

I understand that if I cancel less than 24 hours in advance of a coaching session or if I do not show up without notification, that I may be charged for a session and not reimbursed.

**Initial** __________________

**I have read and consent to the above information and wish to participate in Nutritional Coaching program with my Nutrition Coach from the Shepherd University Wellness Center.**

Name: ________________________________________

Signature: ____________________________________

Date: _________________________________________

# Physical Activity Readiness Questionnaire (PAR-Q)

Name: ______________________________ Date: ______________________

**A Questionnaire for People Aged 15 to 69**

Regular physical activity is fun and healthy, and more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

| YES | NO | |
|---|---|---|
| ☐ | ☐ | 1. Has your doctor ever said that you have a heart condition *and* that you should only do physical activity recommended by a doctor? |
| ☐ | ☐ | 2. Do you feel pain in your chest when you do physical activity? |
| ☐ | ☐ | 3. In the past month, have you had chest pain when you were not doing physical activity? |
| ☐ | ☐ | 4. Do you lose your balance because of dizziness, or do you ever lose consciousness? |
| ☐ | ☐ | 5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity? |
| ☐ | ☐ | 6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? |
| ☐ | ☐ | 7. Do you know of any other reason why you should not do physical activity? |

**If you answered YES to one or more questions**

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and to which questions you answered YES.

- ☐ You may be able to do any activity you want – as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those that are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- ☐ Find out which community programs are safe and helpful for you.

**If you answered NO to all of the questions** →

If you answered NO honestly to *all* PAR-Q questions, you can be reasonably sure that you can:

- ☐ Start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- ☐ Take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

**DELAY BECOMING MUCH MORE ACTIVE:**

- ☐ If you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- ☐ If you are or may be pregnant – talk to your doctor before you start becoming more active

**PLEASE NOTE:**
If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

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# Medical History and Present Medical Condition Questionnaire

Name: ______________________________ Date: ______________________

In order for you to gain the most benefit from this program, we encourage you to answer all of the following questions. If you are uncomfortable with answering a particular question, feel free to leave it blank. Please explain all YES answers at the end of this questionnaire.

## PERSONAL MEDICAL HISTORY

Have you have ever had any of the following conditions?

| YES | NO | |
|---|---|---|
| ☐ | ☐ | 1. Allergies |
| ☐ | ☐ | 2. Loss of hearing |
| ☐ | ☐ | 3. Asthma |
| ☐ | ☐ | 4. Kidney disease |
| ☐ | ☐ | 5. Prostatitis |
| ☐ | ☐ | 6. Colitis |
| ☐ | ☐ | 7. Hepatitis |
| ☐ | ☐ | 8. Liver disease |
| ☐ | ☐ | 9. Elevated liver enzyme test |
| ☐ | ☐ | 10. Pancreatitis |
| ☐ | ☐ | 11. Ulcer |
| ☐ | ☐ | 12. Heart attack |
| ☐ | ☐ | 13. Heart murmur |
| ☐ | ☐ | 14. Positive stress test |
| ☐ | ☐ | 15. Heart valve abnormality |
| ☐ | ☐ | 16. Angina |
| ☐ | ☐ | 17. Heart failure |
| ☐ | ☐ | 18. High cholesterol |
| ☐ | ☐ | 19. High blood pressure |
| ☐ | ☐ | 20. Arthritis/rheumatism |
| ☐ | ☐ | 21. Loss of consciousness |
| ☐ | ☐ | 22. Epilepsy |
| ☐ | ☐ | 23. Convulsions/seizures |
| ☐ | ☐ | 24. Stroke |
| ☐ | ☐ | 25. Diabetes |
| ☐ | ☐ | 26. Thyroid trouble |
| ☐ | ☐ | 27. Anemia |
| ☐ | ☐ | 28. Eczema |
| ☐ | ☐ | 29. Cancer (including skin cancer) |
| ☐ | ☐ | 30. Sleep apnea |

## REVIEW OF CONDITIONS

Do you currently have or have you recently had any of the following?

**EYES, EARS, NOSE, THROAT**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | 31 Difficulty with night vision |
| ☐ | ☐ | 32. Change in vision |
| ☐ | ☐ | 33. Blurred or double vision |
| ☐ | ☐ | 34. Bleeding gums |
| ☐ | ☐ | 35. Frequent nosebleeds |
| ☐ | ☐ | 36. Frequent sinus trouble |
| ☐ | ☐ | 37. Recent hoarseness |
| ☐ | ☐ | 38. Ringing/buzzing ears |
| ☐ | ☐ | 39. Earaches |

**PULMONARY**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | 40. Shortness of breath |
| ☐ | ☐ | 41. Chronic or frequent cough |
| ☐ | ☐ | 42. Brown/blood-tinged sputum |
| ☐ | ☐ | 43. Chest tightness |
| ☐ | ☐ | 44. Wheezing |

**GENITO-URINARY**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | 45. Bladder trouble |
| ☐ | ☐ | 46. Blood in urine |
| ☐ | ☐ | 47. Irregular vaginal bleeding |
| ☐ | ☐ | 48. Currently pregnant |
| ☐ | ☐ | 49. Difficulty starting/stopping urination |
| ☐ | ☐ | 50. Urinating 3 times per night |
| ☐ | ☐ | 51. Frequent or painful urination |
| ☐ | ☐ | 52. Problems with sexual function |

**GASTROINTESTINAL**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | 53. Vomited blood |
| ☐ | ☐ | 54. Persistent diarrhea |
| ☐ | ☐ | 55. Persistent constipation |
| ☐ | ☐ | 56. Frequent abdominal pain |
| ☐ | ☐ | 57. Frequent nausea |
| ☐ | ☐ | 58. Frequent indigestion/heartburn |
| ☐ | ☐ | 59. Black/bloody bowel movement |
| ☐ | ☐ | 60. Hemorrhoids |
| ☐ | ☐ | 61. Trouble swallowing |
| ☐ | ☐ | 62. Hernia |

**CENTRAL NERVOUS SYSTEM**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | 63. Fainting spells |
| ☐ | ☐ | 64. Recurrent dizziness |
| ☐ | ☐ | 65. Frequent headaches |
| ☐ | ☐ | 66. Tremors |
| ☐ | ☐ | 67. Memory loss |
| ☐ | ☐ | 68. Loss of coordination |
| ☐ | ☐ | 69. Difficulty concentrating |
| ☐ | ☐ | 70. Numbness/tingling extremities |

**HEART/VASCULAR**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | 71. Palpitation (irregular heartbeat) |
| ☐ | ☐ | 72. Pain or discomfort in chest |
| ☐ | ☐ | 73. High cholesterol |
| ☐ | ☐ | 74. Swelling of feet |
| ☐ | ☐ | 75. Leg pain while walking |
| ☐ | ☐ | 76. Painful varicose veins |

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## PERSONAL MEDICAL HISTORY

| MUSCULOSKELETAL | | | MISCELLANEOUS | | | | | |
|---|---|---|---|---|---|---|---|---|
| YES | NO | | YES | NO | | YES | NO | |
| ☐ | ☐ | 77. Back trouble/pain | ☐ | ☐ | 81. Bleeding/bruising easily | ☐ | ☐ | 86. Night sweats |
| ☐ | ☐ | 78. Neck trouble/pain | ☐ | ☐ | 82. Enlarged glands | ☐ | ☐ | 87. Undesired weight loss |
| ☐ | ☐ | 79. Joint injury/pain/swelling | ☐ | ☐ | 83. Rashes | ☐ | ☐ | 88. Snoring |
| ☐ | ☐ | 80. Carpal tunnel syndrome | ☐ | ☐ | 84. Unexplained lumps | ☐ | ☐ | 89. Difficulty sleeping |
| | | | ☐ | ☐ | 85. Chronic fatigue | ☐ | ☐ | 90. Low blood sugar |

## ADDITIONAL HEALTH AND LIFESTYLE QUESTIONS

Please answer the following questions honestly:

**YES NO**

☐ ☐ 91. Are you experiencing any stresses, mood problems, relationship difficulties, or substance-related problems for which you would like resource or referral information on a confidential basis?

☐ ☐ 92. Do you occasionally use or are you currently taking any prescription or over-the-counter medications? List name, dosage, and the reason the medication is used on the next page.

☐ ☐ 93. Have you had any surgical operations in the last 10 years?

☐ ☐ 94. Has anyone in your immediate family developed heart disease before the age of 60?

☐ ☐ 95. Do any diseases run in your family?

☐ ☐ 96. Do you currently have a cold/cough, or have you had any in the last two weeks?

☐ ☐ 97. Have you ever been hospitalized? If yes, list date, length of stay, and reason on the next page.

☐ ☐ 98. Are you currently under a doctor's care? If yes, list what you are being treated for on the next page.

☐ ☐ 100. Have you had a change in the size or color of a mole, or a sore that would not heal in the past year?

☐ ☐ 101. Do you have any special concerns regarding your health that you would like to discuss with the doctor?

☐ ☐ 102. Are you a current cigarette smoker?
A. How many packs of cigarettes do you smoke a day? ____________
B. How long have you been smoking? ____________

☐ ☐ 103. Are you an ex-smoker?
A. How many years did you smoke? ____________
B. How many packs a day? ____________
C. When did you quit? ____________

☐ ☐ 104. Have you used chewing tobacco or smoked cigars/pipe in the last 15 years?

105. I drink ______________ beers; ______________ ounces of hard liquor; ______ ounces of wine per week.

106. When were your most recent immunizations?

Tetanus ______________ Flu shot ____________ Pneumovax ______________

107. When were you most recent health maintenance screening tests?

Cholesterol ____________ Results? ____________ PSA (Prostate) ____________ Results? ____________

Mammogram ____________ Results? ____________ Sigmoidoscopy ____________ Results? ____________

Pap smear ____________ Results? ____________

108. Describe any hobbies or recreational activities that have exposed you to noise, chemicals, or dust:

________________________________________

________________________________________

109. Please describe typical weekly exercise or physical activities including any exercise at work:

________________________________________

110. My current diet could be best characterized as (check all that apply):

☐ Low-fat ☐ Low-carb ☐ High-protein ☐ Vegetarian/Vegan ☐ No special diet

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Please explain all YES answers here. List the question number, and add details.

## PERSONAL MEDICAL HISTORY

| QUESTION NUMBER | DETAILS |
| --- | --- |
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# Comprehensive Client Information Sheet

Name: ________________________________ Date: ________________________

## INSTRUCTIONS

This is your comprehensive client information sheet, in which we will ask you to provide some relevant personal information. The answers to these questions are essential in order to allow us to design an optimized individual program for you. Please answer all questions in the most accurate manner possible while being as concise as possible.

## DISCLAIMER

Please recognize the fact that it is your responsibility to work directly with your physician before, during, and after seeking fitness consultation. As such, any information provided is not to be followed without the prior approval of your physician. If you choose to use this information without the prior consent of your physician, you are agreeing to accept full responsibility for your decision.

### COMPREHENSIVE CLIENT INFORMATION SHEET

**PART 1: BASIC INFORMATION**

Name ________________________________ Gender ____________ Age ____________________

Date of birth (month/day/year) _______ _______ _______

**PART 2: BODY COMPOSITION: This will be taken with the Nutritional Coach during your assessment.**

**PART 3: GOALS**

Given the following goals, please rank them in order of importance, with 1 being **most important** and 8 being **least important**.

Improved health_______ Improved endurance_______ Increased strength_______ Sport-specific* ____________

Increased muscle mass_____ Fat loss_______ Increased power_______ Weight gain ______________

*Please provide the sport or athletic event for which you are training:

______________________________________________________________________________

Do you have a specific timeline for achieving a specific goal? If so, please specify:

______________________________________________________________________________

Circle which type of progress is more important to you:

Immediate progress that's less easily maintained Maintainable progress that may not be as rapid

Please explain below:

______________________________________________________________________________

**PART 4: EXERCISE INFORMATION**



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## COMPREHENSIVE CLIENT INFORMATION SHEET

Are you currently exercising regularly (at least 3x per week)?

☐ Yes ☐ No

If you answered **YES**, continue on to the following section.

If you answered **NO**, skip ahead to the section marked **"Not currently exercising"**.

*Complete this section if you ARE currently exercising regularly*

How long have you been consistently exercising without a break?

______________________________

On the following chart, fill in which type of exercise you normally perform each day: resistance training (RT); interval cardio bouts (INT); low-intensity cardio bouts (LIC); sport-specific work (SSW).

| **DAY** | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| **Type of Exercise** | | | | | | | |

On the following chart, fill in your approximate workout duration for each day (in minutes).

| **DAY** | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| **Duration** | | | | | | | |

**Please submit your current exercise regimen along with this form (type it up or write it out for us).**

*Complete this section if you ARE NOT currently exercising regularly*

**If you are not currently exercising regularly, have you ever been on a consistent exercise plan (at least 3x per week)?**

☐ Yes ☐ No

**If you have exercised on a consistent basis previously, how long ago was this and how long did it last?**

### PART 5: MEDICAL AND HEALTH INFORMATION

If you have any diagnosed health problems, list the condition(s). ______________________________

If you are on any medications, please list them. ______________________________

What additional therapies or interventions are being undertaken for the given health problem(s)?

______________________________

If you have any injuries, please list them. ______________________________

What additional therapies or interventions are being undertaken for the given injury(s)?

______________________________

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## COMPREHENSIVE CLIENT INFORMATION SHEET

**PART 6: LIFESTYLE INFORMATION**

What do you do for a living? ____________________

What is the activity level at your job?

☐ None (seated work only) ☐ Moderate (light activity such as walking) ☐ High (heavy labor, very active)

Does your job involve shift work?

☐ Yes ☐ No

If you follow a more regular schedule, do you work days, afternoons or nights? ____________________

Are you a primary caregiver for children, individuals with a disability, or an elder relative?

☐ Yes ☐ No

How often do you travel?

☐ Rarely ☐ A few times a year ☐ A few times a month ☐ Weekly

Please list the physical activities that you participate in outside of the gym and outside of work.

____________________

____________________

Exactly how much money do you spend on groceries per month (provide amounts from your last two grocery bills)? ____________________

How many times per week do you shop for groceries? ____________________

How many meals do you eat in restaurants and/or fast food places per week? ____________________

Exactly how much money do you spend on supplements per month? ____________________

If you have any known food allergies, please list them below.

____________________

Are there any other foods to which you're particularly sensitive (i.e., which cause excessive gas, bloating, stuffiness, or congestion)?

____________________

If you're currently using any nutritional supplements, please list them (as well as the doses you're taking) below.

____________________

Please provide a three-day dietary record (attached). Be sure that these records are representative of the last few months of your dietary intake. In other words, if you just decided to get in shape two weeks ago and changed your diet dramatically, you should give us an indication of how you had been eating habitually prior to the recent change.

How long have you been eating in the manner recorded on your dietary record? (If your answer is less than one month, please fill out your record according to your prior intake before this recent month.)

____________________

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COMPREHENSIVE CLIENT INFORMATION SHEET

Please fill out the following timetable with your most normal daily schedule listing the time you wake up, work and have breaks, work out and go to sleep.

| A.M. | | P.M. | |
|---|---|---|---|
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## COMPREHENSIVE CLIENT INFORMATION SHEET

**MISCELLANEOUS INFORMATION**

If there is any other information you think might be relevant to your program design, please share it with us below.

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Please share your most frequent health, nutrition, or physique complaints and/or dissatisfactions with us.

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

## The "How You Should Feel Timeline"

While you are doing your 3-day food journal you will need to observe and record how you feel immediately after finishing and every hour afterward (in the notes section using the scale 0-10 where 10 is the hungriest you've ever been). If you've eaten the right amount for fat loss, you might feel like this:

**Immediately after-** You're probably still a little hungry. It will take roughly 15-20 minutes to get a sense of satisfaction from a meal. If you're a fast eater, wait it out before you go for more (3-5).

**One hour after finishing-** You should still feel satisfied with no desire to eat another meal (0-2).

**Two hours after finishing-** You may start to feel a little hungry, like you could eat something, but the feeling isn't overwhelming. (0-1)

**Three to four hours after finishing-**You should feel like it's time for the next meal. Your hunger should be around a 7 or 8 out of 10, but may be more or less depending on when you exercised and what your daily physical activity level is. Not really hungry yet? You likely had too much food at your previous meal.

**Four or more hours after finishing-**You're quite hungry, like nothing is getting between you and the kitchen. You're at 8 or 9 out of 10. This is when the "I'm so hungry I could eat anything" feeling appears.

(Obviously, if you let your hunger get this far you may make poor choices.)

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# Three-Day Dietary Record

It is important that this record be both accurate and representative of your normal dietary intake. Thus it is essential that you do not alter your normal eating habits in any way and that you record as precisely as possible every single item that you consume (this includes water, vitamins, condiments, etc.). To do so, you must follow a few simple instructions (listed below). The purpose here is to correctly record and quantify your normal intake, not to judge it. If you change your eating habits in any way, then we cannot accurately analyze your typical diet. The procedure may seem somewhat cumbersome, but remember, it is only three days.

## INSTRUCTIONS

• Keep a pen and paper with you at all times to record your intake including food item, quantity, and notes. This is imperative as snacks are typically consumed unpredictably and, as a result, it is impossible to record them accurately unless your recording forms are nearby.
• Use a small food scale if you have one, or use standard measuring devices (e.g., measuring cups, measuring spoons) to record the quantities consumed as accurately as possible. If you do not eat the entire item (for instance a portion of an apparently delicious hastily prepared casserole of leftovers that turned out to be not so delicious), re-measure what's left and record the difference.
• Record combination foods separately (e.g., hot dog, bun, and condiments) and include brand names of food items (list contents of homemade items) whenever possible. For packaged items, use labels to determine quantities.
• Record three days that are representative of your normal intake. Therefore if your weekdays are different from your weekends, pick two weekdays and one weekend. Likewise, if your M, W, and F are different from your T and Th and all these days are different from your Sat and Sun, you should pick one day to represent each unique schedule.

### EXAMPLE: DIETARY RECORD: DAY 1

| FOOD ITEM | QUANTITY | NOTES & "How You Should Feel Timeline" |
|---|---|---|
| **Breakfast/ 8am** | | 8am- 2 |
| *2 pieces of toast* | *2 pc* | 9am-1<br>10am- 5 |
| *Margarine* | *1 T* | 11am- 8<br>12pm-8 |
| *Orange Juice* | *6 oz* | |
| **Lunch/ 12:30pm** | | |
| *Small pizza* | *400 g* | *Pepperoni, mushroom, cheese* |
| **Dinner /6pm** | | |
| *Chicken* | *6 oz* | |
| *Baked potato* | *6 oz* | |
| *Mixed vegetables* | *1 c* | *Peas, carrots, corn* |

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## DIETARY RECORD: DAY 1

| **FOOD ITEM**<br>(Include brand names) | **QUANTITY**<br>(g, mL, tablespoons [T], teaspoons [t], cups [c], etc.) | **NOTES**<br>(Include ingredients & amounts of homemade items)<br>0-10 scale for how you feel every hour |
|---|---|---|
| 1. | | |
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## DIETARY RECORD: DAY 2

| **FOOD ITEM** (Include brand names) | **QUANTITY** (g, mL, tablespoons [T], teaspoons [t], cups [c], etc.) | **NOTES** (Include ingredients & amounts of homemade items) 0-10 scale for how you feel every hour ) |
|---|---|---|
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## DIETARY RECORD: DAY 3

| **FOOD ITEM**<br>(Include brand names) | **QUANTITY**<br>(g, mL, tablespoons [T],<br>teaspoons [t], cups [c], etc.) | **NOTES**<br>(Include ingredients & amounts of homemade items<br>0-10 scale for how you feel every hour ) |
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# Readiness for Change Questionnaire

One of the most important things you can do to develop new daily practices is to understand your readiness for change. In addition, as your coach, it's useful for me to understand how willing you are to adopt some new practices, as slowly or as quickly as feels right for you.

Simply answer the questions below by selecting the response most appropriate to your situation. Together we'll calculate your score.

## READINESS FOR CHANGE QUESTIONNAIRE

| QUESTIONS: | RESPONSES AND SCORING |
|---|---|
| 1. Do you look in the mirror and feel frustrated, upset, or humiliated because of how your body looks? | a) Yes (+3)<br>b) I'm not sure (0)<br>c) No (–3) |
| 2. When you feel run down and tired, what do you think is the source of these feelings? | a) Getting older (–1)<br>b) My lifestyle choices (+3)<br>c) Something else altogether (–3) |
| 3. Are you taking any medications for heart disease, high blood pressure, or type II diabetes that you didn't have to take when you were younger? | a) Yes, I'm on two or more of these medications (+3)<br>b) Yes, I'm on only one of these medications (+1)<br>c) No, I'm not on any of these medications (–3) |
| 4. If your fitness has deteriorated over the years, how do you explain the fact that you're in worse shape than when you were younger but haven't changed your habits at all? | a) I think it's my family history (–1)<br>b) I think it's that I'm less active (+3)<br>c) I think it's a natural consequence of aging (–1)<br>d) I don't know why it's happening (0) |
| 5. If you don't have anyone to exercise with regularly, are you willing to look for a physical activity partner? | a) Yes (+5)<br>b) No (–5) |
| 6. Are you willing to join a gym today? | a) Yes (+3)<br>b) No (–3) |
| 7. If someone told you that you'd need to throw away all the foods in your cupboards today and go shopping for different foods that are more appropriate to your goal, would you do it? | a) Yes (+5)<br>b) No (–5) |
| 8. If an expert presents some information on diet and exercise that contradicts what you currently believe, what approach will you take? | a) Keep an open mind and give it a try (+3)<br>b) Ask a friend (0)<br>c) Ignore the advice (–3) |
| 9. Are you willing to have a meeting with your friends and loved ones and share your behavior goals and desired outcomes with them? | a) Yes, right away (+5)<br>b) Yes, but not just yet (–3)<br>c) No (–5) |

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## READINESS FOR CHANGE QUESTIONNAIRE

| QUESTIONS: | RESPONSES AND SCORING |
| --- | --- |
| 10. If your work environment presents significant barriers to you exercising and eating well, would you consider speaking to your employer about changing some of these conditions or are you willing to find new employment? | a) Yes (+5)<br>b) No (–5) |
| 11. Are you ready to spend less time with people who offer little or no social support for your goals while spending more time with those who do offer support? | a) Yes (+5)<br>b) No (–5) |
| 12. Can you accept responsibility for the way your body is today and understand that, while your old habits don't make you a bad person, they still need to be changed? | a) Yes (+5)<br>b) No (–5) |
| 13. If a friend or loved one suggests that you don't have what it takes to get into great shape because you've failed before or for some other reason, what will be your response? | a) I can do it (+2)<br>b) I know I've got to make some changes but I'll take it one day at a time (+5)<br>c) Maybe I can't do it (–5) |
| 14. Are you willing to wake up in the morning a bit earlier and stay up at night a bit later to accomplish your goals? | a) Yes (+5)<br>b) No (–5) |
| 15. Are you willing to slowly work up to five hours of physical activity each week? | a) Yes (+5)<br>b) No (–5) |

**YOUR SCORE AND WHAT IT MEANS**

**21 to 63:**
It's clear that you're ready, willing, and able to adopt some new daily practices. Getting to this point is never easy. So congratulations. I look forward to helping you take that enthusiasm and turn it into results.

**-20 to +20:**
If you scored in this range, it seems like you're on the fence. You may be frustrated with the way things are but a little nervous about changing the way you do things today. Those feelings are totally normal and natural. I'm happy to help you move forward at the right pace for you.

**-61 to -21:**
From the results of your questionnaire, it seems like you're apprehensive about the change process. And that's totally okay. Most of my new clients experience the same thing, as this area can feel completely foreign to them. At this point, I'm happy to simply provide a healthy environment for you to consider adopting some new daily practices. They can be as small as you like; we'll go at your pace.

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# Initial Recovery Assessment

BASELINE STRESS/RECOVERY ASSESSMENT

MOOD QUALITY

Rate the following mood qualities throughout the day on a scale of 0 to 5 as follows:

**Appetite**
0 = No appetite; 5 = Very hungry

**Sleep quality**
0 = Poor sleep; 5 = Very good sleep

**Tiredness**
0 = No tiredness; 5 = Very tired

**Willingness to train**
0 = No willingness; 5 = Very excited to train

Record your resting heart rate (taken first thing in the morning while seated, not standing) below. Place your index and middle finger on either your carotid artery (neck) or your radial artery (inside of your wrist) and count the number of beats you feel in 60 seconds. Resting morning heart rate (beats/minute): ____

# Baseline Blood Chemistry Assessment

This assessment is not required for nutritional coaching but would be beneficial. A complete blood profile test, performed by your doctor, will assess your overall blood and cellular health as well as your susceptibility to disease. If you have the following information already, please include the values below.

BASELINE BLOOD CHEMISTRY ASSESSMENT

**GENERAL TESTS**

Typically called SMAC-20, SMA-20, or Chem-20, this basic test looks at 20 different parts of the blood including blood levels of certain minerals, proteins, etc.

**CARDIOVASCULAR RISK PROFILE**

Total cholesterol
LDL
HDL
Triglycerides
C-reactive protein
Homocysteine

**HORMONES**

Testosterone
Free testosterone
IGF-1
Growth hormone
DHEA/DHEAs
Estradiol
SHBG

**PROSTATE TESTS**

PSA

**CARBOHYDRATE TOLERANCE**

Fasted insulin
Fasted glucose

**LIVER FUNCTION TESTS**

Alkaline phosphatase
GGT
SGOT
SGPT
Bilirubin

**KIDNEY FUNCTION TESTS**

Creatinine
BUN
Creatinine/BUN ratio

**THYROID PANEL**

TSH
T3
T4
rT3

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# Social Support Questionnaire

Social support is defined as having a network of people that support your endeavors, contribute positively to your decision-making processes, and are there for you when you need help. Scientists have suggested that people with this kind of network around them can transcend even the worst environments and accomplish great things. Unfortunately, people who don't have this type of network have a harder time accomplishing even modest goals. Remember this: who you are today and who you become in the future has a lot to do with whom you choose to spend your time.

The following questions are designed to assess your level of social support, which strongly influences how well you follow any nutrition or exercise program. Simply answer the questions below by selecting the response most appropriate to your situation. Once you've completed all the questions, your score will be calculated. And remember, be honest. You're doing this exercise to find the areas of your life that might present challenges to your progress.

A word of caution: once you recognize your challenges it's easy to blame them for your outcomes. Don't do this. Outside factors can affect you – if you let them. But you're in control. You have the power to place yourself in the right environment, so use it!

## SOCIAL SUPPORT QUESTIONNAIRE

| QUESTIONS: | RESPONSES AND SCORING |
|---|---|
| 1. Do the people with whom you spend each day (at work or at home) follow healthy lifestyle habits such as exercising regularly, watching what they eat, and taking nutritional supplements? | a) Yes, most of them do. (+3)<br>b) About half do and half don't. (0)<br>c) No, most of them don't. (–3) |
| 2. Does your spouse or partner follow healthy lifestyle habits such as exercising regularly, watching what s/he eats, and taking nutritional supplements? | a) Yes, my spouse/partner does. (+5)<br>b) No, my spouse/partner doesn't. (–5)<br>c) I don't have a spouse or partner. (0) |
| 3. When you want to perform some physical activity such as going for a workout or taking a hike, is it easy for you to find a partner to go with you? | a) Yes, it's easy to find a partner. (+2)<br>b) Yes, but very infrequently. (0)<br>c) No, they never do. (–4) |
| 4. At your workplace, do your coworkers regularly bring in treats like cookies, donuts, and other snacks? | a) Yes, they often do. (–4)<br>b) Yes, but I typically don't indulge (0)<br>c) No, they don't (+5) |
| 5. If you go out to eat more than once per week, do the people you dine with order healthy selections? | a) Yes, they always do. (+2)<br>b) Only about half of the time. (0)<br>c) No, they never do. (–2) |
| 6. Do you belong to any clubs, groups, or teams that meet at least twice per week and do some physical exercise (this does not include a health club membership)? | a) Yes, I've been a member for years. (+5)<br>b) Yes, I've just started. (+2)<br>c) No, I don't. (0) |
| 7. Do you belong to a health club and attend, on average, at least three times per week? | a) Yes, I've been doing this for at least 1 year. (+2)<br>b) Yes, I've just joined. (+1)<br>c) No, I don't. (0) |

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## SOCIAL SUPPORT QUESTIONNAIRE

| QUESTIONS: | RESPONSES AND SCORING |
|---|---|
| 8. When discussing your nutrition and exercise goals with friends, do they seem interested in getting on board, or do they think you're crazy? | a) They're very interested. (+2)<br>b) They're not interested. (0)<br>c) They think I'm crazy. (–2) |
| 9. Do the people you live with bring home foods that aren't considered healthy or good for you? | a) Always (–5)<br>b) Sometimes (–3)<br>c) Never (0) |
| 10. Do the people you live with bring home foods that are considered healthy or good for you? | a) Always (+5)<br>b) Sometimes (0)<br>c) Never (–5) |
| 11. Do the people you live with or work with schedule activities for you that interfere with your pre-established exercise time? | a) Always; they don't respect my time. (–3)<br>b) Sometimes; they don't think about it. (–1)<br>c) Never; they respect this time. (+3) |
| 12. Do those around you bring nutrition, exercise, or supplement information to your attention so that you can stay informed about these topics? | a) Always (+5)<br>b) Sometimes (+2)<br>c) Never (0) |

### YOUR SCORE AND WHAT IT MEANS

**28 to 38 total points:**
Congratulations, it looks like you've got a great social support network around you, a group of people that'll help support your desire to change some of your daily practices. Of course, that's not all you'll need to be successful. But it's a great start.

**5 to 27 total points:**
It looks like you've got some social support around you but there may be a few areas that will present challenges. Being aware of your social temptations, as indicated above, is a great place to begin. Together we can work on strategies for being successful in the face of those challenges

**4 to –14 total points:**
Your social support is lacking and may need a makeover. However, you're not alone here. Many people struggle with social support. And that's why our coaching together will provide some strategies for enhancing your support network.

**–15 to –31 total points:**
This score is quite low and may signal some definite challenges in your work and at-home environments, as well as in your relationships. These can often lead to old habits surfacing as many food related problems are really relationship and environment problems. However, this questionnaire will help us isolate the main challenges. And together we'll work on overcoming them.

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