RAD GYM PTY LTD ATF RAD GYM Trust
ABN: 28 301 566 007
Mobile: 0488 709 839
Email: radgym2023@gmail.com

48 Young Road, COWRA, NSW 2794

RAD GYM

WELCOME LETTER

Dear Valued Client.

Thank you for your expression of interest in working with me, an Accredited Nutritionist.

We are fortunate at RAD GYM to have the capacity to manage both your exercise and nutritional needs to ensure you are getting the maximum benefit from your diet, training and exercise, improving long term health and meeting personal goals you may have along the way.

My aim is to work closely with you to determine the appropriate nutritional advice/plan for you to implement into your daily routine that not only directs you towards reaching your goals, but does so by working into and around your lifestyle.

Please see attached the following documents to be filled out before your initial consultation;

- Nutritional Advisor Risk-Stratification Screening Tool (RSST)
  - Please record current body weight & height in Part B, Question 1.
  - Depending on your health status, you may fall outside the Scope of Practice of a Nutritionist and require referral to a Dietitian for further nutritional advice. Please read carefully and let me know if your responses indicate risk factors present.
- Client Questionnaire
  - Please provide as much accurate information/detail as possible.
- Current Exercise Regime
  - Please provide as much accurate information/detail as possible.
- Food Diary
  - up to 5 days of current food/drink intake. Please be as accurate as possible.
- Referral to your GP (this is optional)
  - The referral would be for your GP to order blood tests to determine important vitamin & mineral levels. This will assist me in developing a more personalised nutrition plan with the aim of bringing abnormal vitamin & mineral levels into balance.

Once completed, please return via;

- Email to radgym2023@gmail.com.

- Arrange for hard copies to be returned to me personally (to maintain client-professional confidentiality).

- Please be sure to include copies of blood test results &/or any other correspondence received from your GP for reference.

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Fees & Payment Terms

The cost of a 12 week nutrition program is $480. You will receive a $120 voucher with Cowra Health & Wellness Hub, to be issued during our initial consultation.

Please note that full payment will be required by the end of Week 4 of the program OR a weekly payment plan ($40/week) must be agreed to during our initial consultation.

If you have any questions or require assistance completing the forms, please give me a call or send me a text on 0488 709 839.

Many thanks.

Ryan Downing.
RAD GYM PTY LTD ATF RAD GYM Trust
Cert IV in Fitness (Personal Trainer)
Cert IV in Nutrition (Sports Nutrition Advisor)
Accredited Nutrition Advisor
NCA Membership No. 446

NUTRITIONAL ADVISOR/NRN

RISK-STRATIFICATION SCREENING TOOL (RSST)

NUTRITION COUNCIL AUSTRALIA

This risk-stratification screening tool does not substitute advice from an appropriately qualified Medical or Allied Health Professional. This risk-stratification screening tool does not promise or warrant against injury or death and no guarantee of protection should result from the use of this risk-stratification tool. No liability or responsibility in any shape or form can be accepted by Nutrition Council Australia (NCA), for any injury, loss, harm or damage that may emerge or become apparent from any person acting on the instruction of (or any statement or information) this risk-stratification screening tool.

CLIENT DETAILS:

CLIENT NAME:			
DATE:		**DOB:**	
CONTACT DETAILS:	PH	**GENDER:**	
	EMAIL		
CLIENT SIGNATURE:			

SECTION 1: IDENTIFY THE CLIENT'S CURRENT HEALTH STATUS

Due to the increased risk and challenges that medical conditions can have on client care, it is critical that clients who fall outside the scope of practice for a Nutritional Advisor/NRN are identified. Section one of the industry endorsed RSST focuses on identifying the client's current health status and the need for referral.

There are two components within Section 1 of the RSST that collect vital information about the client, these include:

PART A) Identify current medical conditions.

PART B) Identify 'at risk' factors.

PART A) IDENTIFY CURRENT MEDICAL CONDITIONS

OBJECTIVE: To identify if an individual presents with any known diseases, or signs or symptoms of disease, who may be classified as a higher risk of an adverse event under the guidance of a Nutritional Advisor/NRN.

The potential client should answer yes or no to the following questions:		Yes	No
1	Are you pregnant or breastfeeding?		
2	Are you under the age of 16 years old (0-15 years old)?		

The following questions refer specifically to 'chronic health conditions' (an illness persisting for a long time or constantly recurring).

3	Have you been medically diagnosed with any eating disorder (i.e., anorexia nervosa, anorexia bulimia, binge eating disorder)? *If yes, please indicate below:*		
4	Have you been diagnosed with diabetes mellitus (i.e., pre-diabetes, type I, type II & gestational diabetes)? *If yes, please indicate below:*		
5	Have you been diagnosed with coeliac disease?		
6	Have you been diagnosed with cancer?		
7	Have you been diagnosed with renal disease?		
8	Have you ever had bariatric surgery (i.e gastric sleeve, gastric bypass, lap-band)? *If yes, please indicate below:*		
9	Have you been diagnosed with any of the following gastrointestinal tract issues? Diverticulitis, bowel obstructions and bowel resections, irritable bowel syndrome (IBS), inflammatory bowel disease (IBD) including ulcerative colitis and/or Crohn's disease. *If yes, please indicate below:*		
10	Have you been diagnosed with thyroid disease (i.e., hypothyroidism or hyperthyroidism)? *If yes, please indicate below:*		
11	Are you currently taking any prescribed medication for blood pressure, cardiovascular disease or high cholesterol, such as ACE inhibitors, beta blockers, warfarin or statins? *If yes, please list the medication(s) below and provide a reason for taking the medication(s):*		

If the individual answers 'YES' to any of the above 11 questions, a referral must be made to an Accredited Practising Dietitian (APD) for nutritional advice and support.
**A Nutritional Advisor/NRN must not work with or take the individual on as a client.*

If the individual answers 'NO' to all of the 11 questions above, the Nutritional Advisor/NRN can move onto Section 1: B of the Risk-Stratification Screening Tool.

PART B) **IDENTIFY 'AT RISK' FACTORS**

OBJECTIVE: To identify if an individual presents with any risk factors in which a Nutritional Advisor/NRN would need to refer the individual to a GP for a more detailed assessment and gain medical clearance prior to working with the individual.

The potential client should answer yes or no to the following questions:	Yes	No
1 Is your BMI below 18.5kg/m^2 (<18.5) or above 40kg/m^2 (>40)? BMI = kg/m^2 = Weight ÷ (height x height) *If yes, please indicate your BMI below:* **Current Weight (kg):** **Current Height (cm):**		
2 Have you been diagnosed with any conditions impacting fertility (i.e., polycystic ovarian syndrome, endometriosis)? *If yes, please indicate below:*		
3 Have you been formally diagnosed with any food allergies and/or intolerances? *If yes, please specify food allergy, diagnostic tool and an approximate diagnosis date:*		
4 Have you been formally diagnosed with a mental health condition in which you are required to take medication?		

If the individual answers 'YES' to any of the above 4 questions, a referral must be made to a General Practitioner (GP) for a more detailed assessment and a medical clearance.
**It is only after a clearance and the 'all clear' has been made by the GP that a Nutritional Advisor/NRN can work with the individual.*

If the individual answers 'NO' to all 4 questions above, the Nutritional Advisor/NRN can move onto Section 2 of the Risk-Stratification Screening Tool.

SECTION 2: IDENTIFY POSSIBLE FOOD INTOLERANCES/ALLERGIES

OBJECTIVE: This section identifies possible food intolerances or allergies that an individual may have. This is an important factor in the screening process to identify if an individual may suffer from food intolerances and/or allergies as this may require a more detailed level of assessment by a General Practitioner (GP).

The potential client should answer yes or no to the following questions:	Yes	No
1 Do you experience bloating regularly?		
2 Do you believe you suffer from excessive flatulence?		
3 Do you experience irregular bowel motions (i.e., diarrhoea, constipation, sore to pass, abnormal colours, faecal urgency)? *If yes, please provide details below on the number of eliminations per day, stool colour, stool abnormalities and stool formation where possible:*		
4 Do you believe you suffer from low energy levels? *If yes, please provide more information below:*		
5 Do you suspect you may have any food allergies and/or intolerances? *If yes, please identify why you think you may have an allergy/intolerance and to what specific food:*		

If the individual answers 'YES' to two (2) or more of the above 5 questions, it is 'recommended', however, not mandatory that a referral be made to a General Practitioner (GP) for a more detailed assessment and a medical clearance.
**It is to the discretion of both the individual and the Nutritional Advisor/NRN whether or not nutritional support and guidance will continue under the supervision of the Nutritional Advisor or if the client will be referred to a GP. If the client is happy to receive support under the guidance of the Nutritional Advisor/NRN, then the Nutritional Advisor/NRN can continue to work with the client.*

If the individual answers 'NO' to all of the above 5 questions, the Nutritional Advisor/NRN can begin to provide individual nutritional support and guidance to the client.

SECTION 3: IDENTIFY FAMILY HEALTH HISTORY

OBJECTIVE: This section identifies possible chronic health conditions that present within immediate family members. Having a family health history of a chronic condition does not mean that the client will develop that condition, however, it is important to identify any potential risks.

The potential client should answer yes or no to the following questions:		Yes	No
1	Has an immediate family member (parents or siblings) ever been diagnosed with any of the chronic health conditions outlined in Section 1: A? *If yes, please list the medical condition(s) below:*		
2	If you have answered 'yes' to the above question, have you had a health check within the last 12 months and been cleared for that condition?		

It is recommended that the client undergoes a health check with their general practitioner (GP) if they have answered 'YES' to both questions above (i.e., they have indicated there is a family history of chronic disease and have not had a health check within the last 12 months).

The Nutritional Advisor/NRN can begin to provide individual nutritional support and guidance to the client even if a family history of chronic conditions has been indicated, however, clients should be encouraged to have regular health checks.

ADDITIONAL NOTES (IF REQUIRED):

CLIENT QUESTIONNAIRE

NUTRITION COUNCIL AUSTRALIA

CLIENT DETAILS:

CLIENT NAME:					
DATE:		DOB:		MALE/FEMALE:	
CONTACT DETAILS:	PH:		EMAIL:		

GENERAL DIETARY HABITS:

1)	How many glasses of water do you drink per day?
2)	Do you drink alcohol? (yes/no) *(If yes, how many standard drinks would you have in an average week?)*
3)	Do you ever skip breakfast, lunch or dinner? *(If so, please provide details below)*
4)	Do you drink tea or coffee regularly (yes/no) *(If yes, how many standard cups of tea or coffee would you have per day?)*
5)	Do you feel as though you have a 'bad' relationship with food *(If yes, please provide more details below)*
6)	Do you smoke or have you previously smoked in the past? (yes/no) *(If yes, provide details for how often you smoke per day. If you no longer smoke, please provide details on when you stopped)*

7)	Please list any foods below that you particularly like or dislike.
8)	Besides allergies or intolerances, do you have any other dietary restrictions?
9)	Do you regularly suffer from any cravings? *Please discuss in detail including craving frequency, food type and if you are aware of any triggers.*
10)	Are you currently taking any supplements and/or vitamins? Please list these below and provide dosage details. *(This question is not referring to medications)*
11)	How often do you have a bowel movement? *Please tick the most appropriate box below:*

More than 3 times per day		*1-2 times per day*	*2-3 times per day*
Once every 2-3 days		*A few times per week*	*Once per week*

	Have you tried any diets or approach(s) in the past in an attempt to change any dietary habits? (yes/no) *If you answered yes for the above question, please describe below:* - *The methods/types of diet have you tried in the past to change your dietary habits.* - *Why you stopped/discontinued the approach(s)?*
12)	*On a scale of 1 - 10 (10 being the hardest) how difficult did you find the process of the above approach(s)? (please circle)*

1	2	3	4	5	6	7	8	9	10

HEALTH GOALS AND MOTIVES:

13)	List your top three priorities in life.

14) **What are your current health-related goals?**
Please also provide details on how long you think it will take to achieve these goals?

15) **In what ways do you think your weight is negatively impacting on your health or lifestyle (if any)?**

16) **What is your greatest motivation to become healthy?**

17) **What do you think you would have to change in your diet or lifestyle to enable you to achieve your goals?**

18) **What do you think are the biggest challenges to achieving your goals?**
(Please tick the boxes and explain where possible).

Knowledge	*Willpower*	*Time*
Support	*Finances*	*Boredom*
Energy	*Stress*	*Health Issues*

19) **How confident are you that you can reach your health goals?**

20) **How could I help you increase your confidence?**
(e.g. recipe ideas, handy tips, regular appointments etc)

21) **Are you looking for a full meal plan or would you prefer to adjust your current lifestyle with some additions?**
(If neither, please advise what are you hoping to achieve in today's session?)

OTHER LIFESTYLE FACTORS:

22)	Who do you live with (i.e. family or friends)?
23)	Who does most of the cooking at home?
24)	Are your friends and family supportive of your lifestyle goals?
25)	How frequently do you consume takeaway or eat out at restaurants? Please provide details.
26)	Roughly, how much do you budget for groceries each week?
27)	Do you have access to all basic cooking equipment such as an oven, stove, microwave and blender?
28)	How much sleep are you getting? *(Please provide details on hours of sleep each night as well as details if its broken/unbroken sleep)*

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REVIEW OF CURRENT EXERCISE REGIME

CLIENT NAME: _____

CLIENT DOB: _____

CLIENT OCCUPATION: _____

	Exercise at Work eg: sedentary, light walking, heavy lifting.	Prescribed Exercise Type	How Many Times Per Week	Intensity - Light - Moderate - High	Duration
Activity 1.		N/A			N/A
Activity 2.	N/A				
Activity 3.	N/A				

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Activity 4.	N/A				
Activity 5.	N/A				
Activity 6.	N/A				
Activity 7.	N/A				

Additional Notes:

CLIENT FOOD DIARY

NUTRITION COUNCIL AUSTRALIA

DAY/MEAL	FOOD CONSUMED	AMOUNT	TIME	WHERE	SOCIAL SETTING	ACTIVITY	MOOD

CLIENT FOOD DIARY

NUTRITION COUNCIL AUSTRALIA

DAY/MEAL	FOOD CONSUMED	AMOUNT	TIME	WHERE	SOCIAL SETTING	ACTIVITY	MOOD

CLIENT FOOD DIARY

NUTRITION
COUNCIL
AUSTRALIA

DAY/MEAL	FOOD CONSUMED	AMOUNT	TIME	WHERE	SOCIAL SETTING	ACTIVITY	MOOD

CLIENT FOOD DIARY

NUTRITION COUNCIL AUSTRALIA

DAY/MEAL	FOOD CONSUMED	AMOUNT	TIME	WHERE	SOCIAL SETTING	ACTIVITY	MOOD

CLIENT FOOD DIARY

NUTRITION COUNCIL AUSTRALIA

DAY/MEAL	FOOD CONSUMED	AMOUNT	TIME	WHERE	SOCIAL SETTING	ACTIVITY	MOOD

REFERRAL FORM

NUTRITION COUNCIL AUSTRALIA

REFERRAL DATE:	

NAME:		
BUSINESS NAME:		
ADDRESS:		
CONTACT DETAILS	PH:	FAX:
	EMAIL:	

CLIENT NAME:		**DATE OF BIRTH:**	
CLIENT ADDRESS:			
CONTACT DETAILS:	PH:	EMAIL:	

Dear Sir/Madam.

Thank you kindly for seeing _____ age ___ for _____.
Details for this referral are outlined below:

ADDITIONAL DETAILS	

Thank you in advance for your assistance.

Look forward to hearing from you in the future.

Healthy regards,

Ryan Downing
Accredited Nutrition Advisor
NCA Membership No. 446

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REFERRAL FORM

NUTRITION COUNCIL AUSTRALIA

CONSENT TO REFER

I, _____ give my permission for _____ to communicate with my GP regarding my health status and my progress relating to my nutritional program and/or recommendations. All information provided will be treated confidentially and will not be used for any other purposes or shared with any additional parties.

I can also confirm that I am aware of the following:

- That this referral is being made and I understand that I can withdraw from this referral or from the referred service at any time.
- I consent to the referred parties on this form to receive relevant information from doctors and other Allied Health Professionals, specifically relevant to my nutritional care whilst being a client of.

NAME:	
SIGNATURE:	
DATE:	

If the client is under 18 years of age, authorisation should (where possible) also be provided by a parent/ guardian/carer.

NAME:	
SIGNATURE:	
DATE:	

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