

UCSD Healthy Eating Program Registration Form

To Register

Please complete both pages of this Registration form. Mail to the UCSD Healthy Eating Program, 3855 Health Sciences Drive #0901, La Jolla, CA 92093-0901, along with your check. Upon receipt of the completed forms with payment, program staff will contact you to get started. Contact us if you have questions or need more information (858-822-6790 or info@healthyeating.ucsd.edu).

Contact Information

Name: _____ Gender (circle): M F Date of Birth: _____

Address (Street): _____

Address (City, State, Zip Code): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Fax: _____ Is it OK to call at work ___ yes ___ no

Preferred contact time range _____ Preferred phone (circle one): home work cell

Services

Circle Those Requested

Personalized One-on-One Counseling (Healthy Eating Program) \$495
8 counseling calls (45 min/call)
Computerized dietary analysis with feedback
Educational materials, self-monitoring tools, recipes

Computerized Dietary Analysis with Consultation
2 calls (30 min/call)
First to record your dietary intake
Second to discuss results \$ 95

Total Enclosed \$ _____

Payment in full must accompany registration. Please do not send cash with mailed registration. Make checks payable to UC Regents and write on "memo" line Healthy Eating Program.

Motivation

1. What is/are your primary reason(s) for participating in the Healthy Eating Program? _____

2. How strongly do you believe that the food you eat can protect your health and help to prevent disease?
 Very strongly Strongly Somewhat Not at all Don't know/no opinion
3. How satisfied are you with your current diet?
 Very satisfied—no changes needed Sort of satisfied—could use some improvement
 Not satisfied--needs improvement Don't know/no opinion
4. How committed are you to changing your diet now?
 Very committed Sort of committed Not committed at all Don't know/no opinion
5. How much time would you be willing to commit during the next month to changing your diet (including time on the phone with your counselor)? 3-4 hours/week 2 hours/week
 1 hour/week Less than 1 hour/week Other, please specify: _____

Medical History

6. During the last 5 years, have you been diagnosed with any type of disease, including cancer? Yes ___ No ___
If yes, please describe or list disease(s) or condition(s): _____

7. Are you currently undergoing treatment for this/these disease(s) or condition(s)? Yes ___ No ___
If yes, please describe: _____
8. Are there any foods that you cannot tolerate or routinely avoid? Yes ___ No ___
If yes, please describe or list: _____
9. Can you tolerate a high-fiber diet? Yes ___ No ___
If no, please explain: _____
10. What is your current height? _____ Current weight? _____
- 11 Has your weight changed by more than 5 pounds during the past year? Yes ___ No ___
If yes, please circle: Gained _____ pounds; Lost _____ pounds