

Senior Nutrition Intake Form		Consumer ID# _____	Eligibility: <input type="checkbox"/> Age 60+ Verified By _____ <input type="checkbox"/> Spouse of Participant <input type="checkbox"/> Disabled person residing where the congregate site is located <input type="checkbox"/> Volunteer <input type="checkbox"/> Caregiver
Please complete this form to the best of your ability.		Intake Date: _____ Beginning Date: _____ Termination Date: _____ Reason: _____	
For Office: <input type="checkbox"/> Congregate <input type="checkbox"/> Home Delivered Meals Site/Route: _____		Income Level: Ex. Low / Low / Mod	
First Name, Middle Initial: _____	Last Name _____		Date of Birth: _____ / ____ / ____
Home Address: _____		City: _____	Zip Code: _____ <input type="checkbox"/> Decline to State
Mailing Address: Same As Residential? <input type="checkbox"/> Yes		City: _____	Zip Code: _____ <input type="checkbox"/> Decline to State
Home Phone: _____		Emergency Contact Name: _____	
Alternate Phone: _____		Phone: _____	Relationship: _____
Living Arrangement # of household members <input type="text"/>	What is your approximate household income? \$ _____ per <input type="checkbox"/> month <input type="checkbox"/> year <input type="checkbox"/> Declined to State		Rural Area? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
<input type="checkbox"/> Alone <input type="checkbox"/> Not Alone <input type="checkbox"/> Declined to State <input type="checkbox"/> Missing	Receiving Social Security? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing		
Martial Status? <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Missing <input type="checkbox"/> Declined to state	Female Head of Household? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing		Homebound? <input type="checkbox"/> Yes <input type="checkbox"/> No
Spouses/Partners Name: _____	Medicare Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing		Frail? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Tribal Member? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing		Referred Senior To:
What is your gender? (Check only one) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated			
What was your sex at birth? (Check only one) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated		How do you describe your sexual orientation or sexual identity (Check only one) <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated	
Ethnicity (Check One) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing		Language: <input type="checkbox"/> English speaking <input type="checkbox"/> Non-English/Language: _____	
Race (Check One) <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Laotian <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race <input type="checkbox"/> Other Asian <input type="checkbox"/> Declined to State <input type="checkbox"/> Missing			
Abused? Neglected? Exploited? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing			
Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing			
US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing			
Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing		Veteran Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing	
Cognitive Impairment? <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Early onset Dementia <input type="checkbox"/> Severe <input type="checkbox"/> UNK <input type="checkbox"/> Decline to state <input type="checkbox"/> Missing			
Employment Status? <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> None <input type="checkbox"/> Unemployed <input type="checkbox"/> UNK <input type="checkbox"/> Decline to State <input type="checkbox"/> Missing			

Activities of Daily Living (ADL'S) & Instrumental (IADL's) Assessment/Reassessment Section.

Activities of Daily Living (ADL)	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Decline to State
Eating						
Bathing						
Toileting						
Transferring (bed/chair)						
Walking						
Dressing						
Instrumental ADL's (IADL)	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Decline to State
Meal Preparation						
Shopping						
Medication Management						
Money Management						
Using Telephone						
Heavy Housework						
Light Housework						
Transportation						

Nutritional Risk Assessment Section

Check box next to the number in the "YES" column for those that apply.	Yes
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits or vegetables or milk products.	2
I have 3 or more drinks of beer, liquor or wine per day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 3 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and/or feed myself. (Do you need someone to do it for you)?	2
Total the nutritional score: If equal to or greater than 6, client is at high nutritional risk	
Client's Health Problems: (Do not leave blank. Must input into database)	<input type="checkbox"/> Decline to State

Completed by _____ Date _____