Senior Nutrition Intake Form

Please complete this form to the best of your ability.

For Office:
☐ Congregate
☐ Home Delivered Meals
Site/Route:_____

Consumer ID#
_____
Intake Date: _____
Beginning Date: _____
Termination Date: _____
Reason:_____

Income Level: Ex. Low / Low / Mod

Eligibility:
☐ Age 60+ Verified By_____
☐ Spouse of Participant
☐ Disabled person residing where the congregate site is located
☐ Volunteer
☐ Caregiver

First Name, Middle Initial:	Last Name	**Date of Birth**: / /
Home Address:	City:	Zip Code:_____ ☐Decline to State
Mailing Address: Same As Residential? ☐ Yes	City:	Zip Code:_____ ☐ Decline to State
Home Phone: Alternate Phone:	Emergency Contact Name: Phone: Relationship:	

Living Arrangement
# of household members ☐

☐ Alone ☐ Not Alone
☐ Declined to State ☐ Missing

What is your approximate household income?
$_____ per ☐ month ☐ year ☐ Declined to State

Receiving Social Security?
☐Yes ☐No ☐Decline to State ☐Missing

Rural Area?
☐ Yes ☐ No
☐ Declined to State

Martial Status?
☐ Married ☐ Widowed
☐ Legally Separated ☐ Divorced
☐ Single ☐ Missing
☐ Declined to state

Spouses/Partners Name:

Female Head of Household?
☐Yes ☐No ☐Decline to State ☐Missing

Medicare Eligible?
☐Yes ☐No ☐Decline to State ☐Missing

Tribal Member?
☐Yes ☐No ☐Decline to State ☐Missing

Homebound?
☐ Yes
☐ No

Frail?
☐ Yes
☐ No

Referred Senior To:

What is your gender? (Check only one)
☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female
☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated

What was your sex at birth? (Check only one)
☐ Male ☐ Female
☐ Declined/not stated

How do you describe your sexual orientation or sexual identity (Check only one)
☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving
☐ Questioning/Unsure ☐ Not Listed, please specify: _____
☐ Declined/not stated

Ethnicity (Check One)
☐ Hispanic/Latino ☐Non-Hispanic/Latino
☐ Decline to State ☐Missing

Language:
☐ English speaking
☐ Non-English/Language:_____

Race(Check One) ☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian Indian
☐ Cambodian ☐ Korean ☐ Chinese ☐ Laotian ☐ Filipino
☐ Japanese ☐ Vietnamese ☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander ☐ Other Race ☐ Multiple Race ☐ Other Asian ☐ Declined to State ☐ Missing

Abused? Neglected? Exploited? ☐Yes ☐No ☐Decline to State ☐Missing

Disabled? ☐Yes ☐No ☐Decline to State ☐Missing

US Citizen? ☐Yes ☐No ☐Decline to State ☐Missing

Veteran? ☐Yes ☐No ☐Decline to State ☐Missing

Veteran Dependent? ☐Yes ☐No ☐Decline to State ☐Missing

Cognitive Impairment? ☐None ☐Mild ☐Moderate ☐Early onset Dementia ☐Severe ☐ UNK ☐Decline to state ☐Missing

Employment Status? ☐Full Time ☐Part Time ☐ Retired ☐None ☐Unemployed ☐UNK ☐Decline to State ☐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)*	☐ Decline to State

Completed by _____ **Date** _____

Please submit your completed application to
SOUTH COUNTY: Email: OHenson@CommUnifySB.org or Fax: 805.683.5872
NORTH COUNTY: Email: LBisquera@CommUnifySB.org or Fax: 805.349.8165
or Mail to 5638 Hollister Ave. Suite 230, Goleta, CA 93117