_____ Center - Meal Client Registration Date_____/_____2017

Client information

Last Name	First Name	Ethnicity *(select one)*
		☐ Not Hispanic/Latino ☐ Hispanic/Latino
Nickname or Preferred Name		Race *(select one or more; information collected for federal statistics)*
Address		☐ American Indian/ Alaskan Native ☐ Asian
		☐ Black/African American ☐ Pacific Islander/Native Hawaiian
City		☐ White ☐ Other
Telephone Number	Primary	Sex/Gender
Home ( )	☐	☐ Female ☐ Male ☐ Intersex ☐ Transgender
Mobile ( )	☐	☐ Other
Veteran of US Armed Service ☐ Yes ☐No		Sexual Orientation (optional): ☐ Heterosexual/Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Unsure ☐ If not listed above, please specify.

Date of Birth	Income *(select one)*
Month / Day / Year	☐ $1005. month **or below** (1-person household) ☐ $1006. month **or above** (1-person household) $1353. month **or below** (2-person household) $1354. month **or above** (2-person household ☐ Unknown

Emergency Contacts

Name	Name:
Relationship to Client:	Relationship to Client:
Home Tele. Primary ☐	Home Tele. Primary ☐
Mobile Tele. Primary ☐	Mobile Tele. Primary ☐
Primary Physician	Physician's Tel

Check each question below:	Yes	No
Live alone		
Frail/ Disabled *Having a physical or mental disability that restricts the ability of an individual to perform normal daily tasks, or threatens the capacity of the individual to live independently.*		
Vulnerable *Exposed to unfavorable environmental conditions, or lack of social resources such as language barrier, isolation, no informal support system, income level between 100-200% of the poverty level, or not previously within the service system.*		

********** ADL/IADLs Required for Home Delivered Supplemental meals ONLY **********

INSTRUMENTAL ACTVITIES OF DAILY LIVING In the last 7-days, if you've had some difficulty in performing any of the following tasks by yourself, or required personal or standby assistance, or supervision, check 'impairment'.

1. Preparing Meals…… ☐ Impairment
2. Laundry/Ordinary Housework… ☐ Impairment
3. Heavy Housework…….. ☐ Impairment
4. Shopping…….. ☐ Impairment
5. Managing Medicine…… ☐ Impairment
6. Using Transportation …….. ☐ Impairment
7. Paying Bills/Managing Money…. ☐ Impairment
8. Using the Telephone…… ☐ Impairment

ACTIVITIES OF DAILY LIVING In the last 7-days, if you've had difficulty or required any help in performing the following, check 'impairment'.

1. Bathing…….. ☐ Impairment
2. Dressing…… ☐ Impairment
3. Eating…… ☐ Impairment
4. Getting out of the bed or chair…. ☐ Impairment
5. Walking…… ☐ Impairment
6. Toileting…… ☐ Impairment

Name _____ **Date** _____

Center _____

Determine Your Nutritional Health

The warning signs of poor nutritional health are often overlooked. Use this survey to find out if you are at nutritional risk.

Read the statements below. Circle the number in the column for those that apply to you. Total your nutritional score.

	Yes	No
1. I eat fewer than 2 meals a day; *I eat mostly snacks or 1 complete meal a day.*	3	0
2. I eat alone most of the time.	1	0
3. I eat less than 2 servings of milk or milk products most days; *I eat 0-1 serving a day.*	1	0
4. I eat less than 5 servings of fruit and/or vegetables most days.	1	0
5. I have 3 or more drinks of beer, liquor, or wine almost every day.	2	0
6. Without wanting to, I have lost or gained 10 pounds in the last 6 months. ☐ **lost or** ☐ **gained**	2	0
7. I have an illness or health condition *(such as diabetes, high blood pressure, high cholesterol)* **that made me change the kind and/or amount of food that I eat.**	2	0
8. I take 3 or more different prescribed or over-the-counter drugs every day.	1	0
9. I am not always physically able to shop, cook, or feed myself *(or get someone to do it for me).* **Examples: I need help going food shopping, I need help cooking a meal, or I need help cutting up food on my plate. If 'Yes' to ANY OF THESE, circle 'Yes'.**	2	0
10. I have problems with my teeth or mouth that make it hard to eat some foods.	2	0
11. I sometimes run out of money to buy the food that I need.	4	0
TOTAL		

Total your nutritional score. If it's ….

0-2 Good! Recheck your nutritional score in 6 months.

3-5 You are at moderate nutritional risk. See what can be done to improve your eating habits and lifestyle. Recheck your nutritional score in 3 months.

6 or more **You are at high nutritional risk.** Bring this survey the next time you see your doctor, or check the box below to speak with a registered dietitian free of charge.

☐ **No, I'm not interested.** ☐ **Yes, I'd like to discuss this survey with a nutrition professional**

☐ Male ☐ Female Height _____ Weight _____ (lbs) Tel. # (_____)_____