

Congregate Meals Intake Form

(Information required by State-Confidential)

Name: (Last) _____ (First) _____ Date: _____

Mailing Address _____

Street Address: _____

Date of Birth: ___/___/___ Age: _____ Sex: M F Phone: _____

Live Alone: Yes No Last 4 digits of SS# _____

Income: Single above \$ 902.50/ mo Yes No

Couple above \$ 1,214.17/ mo Yes No

SSI ? Yes No

Race: White Black Indian AI/ PI Hispanic Other _____

Primary Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Physically Impaired? Yes No Wheelchair Oxygen

Diabetic Insulin Dependent

Other Health related problems? _____

Nutritional Risk Assessment (check box)

I have an illness/condition that made me change the kind and /amount of food I eat	<input type="checkbox"/>
I eat fewer than 2 meals a day	<input type="checkbox"/>
I eat fewer than 5 servings if ½ cup each of fruits or vegetables a day	<input type="checkbox"/>
I eat fewer than 2 servings of dairy every day (milk, yogurt, cheese)	<input type="checkbox"/>
I have tooth or mouth problems that make it hard for me to eat	<input type="checkbox"/>
I don't always have the money I need to buy the food I need	<input type="checkbox"/>
I eat alone most of the time	<input type="checkbox"/>
I take 3 or more prescriptions or over-the-counter medications a day	<input type="checkbox"/>
Without wanting to, I have lost or gained 10 pounds in the last 6 months	<input type="checkbox"/>
I am not always physically able to shop, cook and/or feed myself	<input type="checkbox"/>
I have 3 or more drinks of beer, liquor or wine almost everyday	<input type="checkbox"/>
TOTAL	

(0-2- Good 3-5- At risk 6 or more-High Risk)

I authorize the release of information to any agency/hospital in an emergency. Yes No