______________________ Center **Client Registration** Date________/________2018

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

Income ***(select one)***

☐ $ 0 - $1011. month (1-person household)	☐ $ 0 - $1371. month (2-person household)
☐ $1012. - $2,582. month(1-person household)	☐ $ 1372. – $3,531. (2-person household)
☐ $2.583. – month or above (1-person household)	☐ $ 3,532 – month or above (2-person household)

Emergency Contacts

Name (s) :	Telephone #:	Relationship to Client:

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	5. Managing Medicine.................. ☐ Impairment
2. Laundry/Ordinary Housework... ☐ Impairment	6. Using Transportation .... ☐ Impairment
3. Heavy Housework...................... ☐ Impairment	7. Paying Bills/Managing Money.... ☐ Impairment
4. Shopping.................................. ☐ 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	4. Getting out of the bed or chair.... ☐ Impairment
2. Dressing...... ☐ Impairment	5. Walking.. ☐ Impairment
3. Eating......... ☐ Impairment	6. Toileting...................................... ☐ Impairment

For the office use only

Please check the activities/classes registering at the center

☐ Congregate Meals	☐ Education
☐ Physical Activity	☐ Socialization/Recreation
☐ Information and Assistance (I&A)	☐ Other

Name ______________________________ Date: ________________

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 questions 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 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 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 physically able to shop, cook, or feed myself. 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 ....

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

Score of 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.

Score of 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.

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

☐ Male ☐ Female Height ________ Weight _______ (lbs) Tel. # (______) _____________

The best time to reach me is ____________