

AgeOptions Registration for Congregate Meals

This form must be completed by the appropriate Congregate nutrition provider.

Client Demographic Information					
Name:		Phone Number:		Date:	
Address:		E-mail:		DOB:	
Race: Caucasian__ African American__ Asian__ Hispanic__ Pacific Islander__ Alaska Native__ American Indian__ Other_____			Marital Status: M__ D__ S__ W__ Legally separated ____ Domestic partner ____		Gender: M__ F__ Other _____
Ethnicity: Hispanic or Latino		Not Hispanic or Latino			
Limited English Speaking: Yes No If yes, specify language spoken:		Below Poverty: Yes No Monthly Income:		Lives Alone: Yes No	
Major Health Problems (check all that apply)					
Ambulation_____ Hearing_____ Vision_____ Other: _____					
Nutrition Risk Screen (circle points under Yes or No)					
	Y	N		Y	N
Have you made changes in the way you eat because of an illness or medical condition?	2	0	Do you eat alone most of the time?	1	0
Do you eat fewer than two meals a day?	3	0	Have you lost or gained ten pounds in the last six months without wanting to?	2	0
Do you eat few fruits and vegetables?	1	0			
Do you eat fewer than 2 servings of dairy products per day?	1	0	Are you unable to shop, cook, and feed yourself?	2	0
Do you not have enough money to buy the food you need?	4	0	Do you have three or more drinks per day?	2	0
Do you have trouble eating well due to problems with chewing/swallowing?	2	0	Do you take three or more prescribed or over-the-counter drugs a day?	1	0
TOTALS			TOTALS		
Combined column totals: ___/21 possible points Six or more points = high nutritional risk					
Additional nutrition information					
Special Diet Needs: General _____ Diabetic _____			Does client have difficulty swallowing: Yes No		
Client food source for the weekends:			Dietary restrictions:		
			Food allergies:		
Other Contacts Information					
Emergency Contact Name:		Home phone:		Cell phone:	
Address:		E-mail:			
Emergency Contact Name:		Home phone:		Cell phone:	
Address:		E-mail:			
Authorization of Release of Information					
I give permission to _____ to discuss my needs with their and AgeOptions Staff.					
Client Signature:				Date:	