

2020 Consumer Congregate Nutrition Assessment Form

Updated March 10, 2020

Basic Client Information:		Date of Assessment: / /	
*Last Name:	*First Name:	Middle Initial:	
*Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	*Date of Birth: / /	*Age:	
Residential Address:			
*Address Line 1:		*Address Line 2(Apt #, Unit #, Floor #):	
*City:	*State:	*Zip:	
*County:	Phone (Home):		
Phone (Mobile):	Phone (Work):		
Location Comments (Directions):			
Email Address:		Are you receiving Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is your marital status ? <input type="checkbox"/> Married/Domestic Partner <input type="checkbox"/> Single <input type="checkbox"/> Widowed		Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Lives : <input type="checkbox"/> Alone <input type="checkbox"/> With others	What is your primary language?		
*What is your race?	*Ethnicity? <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino		
*Are you visually impaired (cannot be corrected with glasses)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you caregiver to anybody? <input type="checkbox"/> Yes <input type="checkbox"/> No		*Are you a grandparent, raising grandchildren:)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you working? <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Volunteering <input type="checkbox"/> Seeking employment <input type="checkbox"/> No		Are you willing to volunteer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How many people live in your household?			
What is your monthly individual income?		What is your monthly household income?	
*What is your monthly income range?	<input type="checkbox"/> \$1,063 or less <input type="checkbox"/> \$1,064 to \$1,327 <input type="checkbox"/> \$1,328 to \$1,965 <input type="checkbox"/> \$1,966 or more	*What is you and your spouse's combined monthly income range?	<input type="checkbox"/> \$1,437 or less <input type="checkbox"/> \$1,438 to \$1,796 <input type="checkbox"/> \$1,797 to \$2,658 <input type="checkbox"/> \$2,659 or more
Mailing Address, if different from physical Address:			
Mailing Address Line 1 (if different from physical address):			
Mailing Address Line 2 (Apt #, Unit #, Floor #):			
Mailing City:	Mailing State:	Mailing Zip Code:	
Are you interested in receiving nutrition counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No			

How did you hear about our services?

- AAA Brochure
 AAA Newsletter
 Channel 9 Senior Source (TV)
 Congregate Meal Site
 From a Current Client
 From a Friend/Relative
 Senior Fair
 Walk-In
 Web Site
 Other

Do you want to hear about other services? Yes No If yes, how can we contact you? Email Mail Phone

When is the best time to contact you? Please tell us what services you would like to receive:

Emergency contact name: _____ Relationship: _____ Phone Number: _____

Physician's first name: _____ Physician's last name: _____ Phone Number: _____

Nutrition Questions - Please fill out if you receive meals at a meal site:	Yes	No	Yes Score
* 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 almost every 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.			2
What is the consumer's nutritional risk score? (0-2 = No Risk 3-5 = Moderate Risk 6 or more = High Risk)	Total 'Yes' Score		_____

I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service provider and I herewith give my consent to do so.

(If filled out by assessor or via phone, please have assessor check here and sign below).

Signature _____ Date _____

Office use only: Information filled out by _____ Date _____