Congregate Lunch Program

Client Registration Form

_____ Center **Date _____/_____ / 2024**

Client Information

Last Name **First Name** **Nickname or Preferred Name** **Address** **City**	**Ethnicity** ***(select one)*** ☐ Not Hispanic/Latino ☐ Hispanic/Latino **Race** ***(select one or more; information collected for federal statistics)*** ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Pacific Islander/Native Hawaiian ☐ Other
Telephone Number ***Primary*** Home: (_____) _____ ☐ Mobile: (_____) _____ ☐ Email: _____	**Sex/Gender** ☐ Female ☐ Male ☐ Intersex ☐ Transgender ☐ Other **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)	**One Person**	**Two Persons**
FPL – Federal Poverty Level	☐ $0 - $1,255 per month	☐ $0 - $1,703 per month
Between FPL & Elder Index	☐ $1,256 - $3,034 per month	☐ $1,704 - $4,011 per month
	☐ $3,035 per month or above	☐ $4,012 per month or above

Emergency Contacts

Name	**Name**
Relationship to Client	**Relationship to Client**
Home Phone *Primary* ☐	**Home Phone** *Primary* ☐
Mobile Phone *Primary* ☐	**Mobile Phone** *Primary* ☐
Primary Physician	**Physician's Phone**

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.		

Client's Name _____

DETERMINE YOUR NUTRITIONAL HEALTH - *Required*	**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.	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, 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.

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

☐ Male ☐ Female Height _____ Weight _____ (lbs)

Telephone # (_____)_____

The best time to reach me is _____

Client's Name _____

DETERMINE IF YOU ARE AT RISK FOR MALNUTRITION - *Required*		
1. Have you recently lost weight without trying?	☐ *No* ☐ *Yes*	
If yes, how much weight have you lost?	☐ *2 – 13 lbs.*	Score 1
	☐ *14 – 23 lbs.*	Score 2
	☐ *24 – 33 lbs.*	Score 3
	☐ *34 lbs. or more*	Score 4
	☐ *Unsure*	Score 1
		Weight Loss Score: _____
2. Have you been eating poorly because of decreased appetite?	☐ *No*	Score 0
	☐ *Yes*	Score 1
		Appetite Score: _____
		TOTAL SCORE: _____

FOOD INSECURITY SCREENING - *Required*			
1. In the past twelve months, have you worried about whether your food would run out before you had money to purchase more?	☐ *Never*	☐ *Sometimes*	☐ *Often*
2. In the past twelve months, my food didn't last and I didn't have the money to purchase more.	☐ *Never*	☐ *Sometimes*	☐ *Often*

***** THIS SECTION REQUIRED FOR HOME DELIVERED MEALS ONLY *****

INSTRUMENTAL ACTIVITIES OF DAILY LIVING – In the lasts 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. Ordinary Housework	☐ Impairment	6. Using Transportation	☐ Impairment
3. Laundry	☐ 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'.			
Bathing	☐ Impairment	Getting out of bed or chair	☐ Impairment
Dressing	☐ Impairment	Incontinence	☐ Impairment
Eating	☐ Impairment	Toileting	☐ Impairment