



Registration for Congregate Meals

Name of Site: _____ **New Client** **Renewal**

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

Older Adult Demographic Information						
Date:		Name:		DOB:		
Address:			City:	State:	Zip:	
Email:			Phone:		Cell Phone:	
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		Race: <input type="checkbox"/> White <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Domestic Partner		Gender: <input type="checkbox"/> M <input type="checkbox"/> F Other:
Limited English Speaking: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify language: _____		Monthly Income: _____ Below Poverty: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Lives Alone <input type="checkbox"/> Lives with Others # of Individuals in Household: _____		
Major Health Problems (check all that apply)						
<input type="checkbox"/> Ambulation <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Other: _____						
Nutrition Risk Screen (select Yes or No)						
	Y	N		Y	N	
I have an illness or condition that made me change the kind and/or amount of food I eat.	<input type="checkbox"/>	<input type="checkbox"/>	I don't always have enough money to buy the food I need.	<input type="checkbox"/>	<input type="checkbox"/>	
I eat fewer than 2 meals per day.	<input type="checkbox"/>	<input type="checkbox"/>	I eat alone most of the time.	<input type="checkbox"/>	<input type="checkbox"/>	
I eat few fruits and vegetables, or milk products.	<input type="checkbox"/>	<input type="checkbox"/>	I take 3 or more different prescribed or over-the-counter drugs a day.	<input type="checkbox"/>	<input type="checkbox"/>	
I have 3 or more drinks of beer, liquor, or wine almost every day.	<input type="checkbox"/>	<input type="checkbox"/>	Without wanting to, I have lost or gained 10 pounds in the last 6 months.	<input type="checkbox"/>	<input type="checkbox"/>	
I have tooth or mouth problems that make it hard for me to eat.	<input type="checkbox"/>	<input type="checkbox"/>	I am not always physically able to shop, cook, and/or feed myself.	<input type="checkbox"/>	<input type="checkbox"/>	
Totals		0	Totals		0	
Six or more points = High Nutritional Risk			Combined Column Totals: _____/21 Possible Points			
<input type="checkbox"/> Nutritional Risk was explained to client. <input type="checkbox"/> Client is considered at High Nutritional Risk. A recommendation was made to follow-up with a healthcare provider.						
Additional Nutrition Information						
Does Older Adult have difficulty chewing/poor dental health? <input type="checkbox"/> Yes <input type="checkbox"/> No			Special Diet <input type="checkbox"/> General <input type="checkbox"/> Diabetic Needs: <input type="checkbox"/> Other:			
Client food source for the weekends:			Dietary Restrictions:			
Food Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify: _____						
NOTE: It is the client's responsibility to review the weekly menu and bring any allergy concerns to the attention of the nutrition provider. When feasible, the provider will supply a special meal to meet the dietary needs of the client. <input type="checkbox"/> The client was informed of the possibility that foods may contain or come into contact with food allergens.						
Other Contact Information						
Emergency Contact Name #1:			Daytime/Cell Phone:			
Emergency Contact Name #2:			Daytime/Cell Phone:			
Authorization of Release of Information						
I give permission to the provider and/or the Area Agency on Aging Staff to discuss my needs.						
Client Signature:			Date:			

Staff Person Initials: _____