



INSERT LOGO HERE

Sign up today to enjoy wholesome meals with friends!

Today's Date: / /		Preferred Phone: ()	
First Name:		Last Name:	MI:
Date of Birth: / /		Email:	
Address:	City:		State:
			Zip:

The following data is asked by our funders and will not be disclosed by name.

Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Other:
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Check the racial categories that apply to you:

- White Asian African American/Black American Indian/Alaskan Native
- Native Hawaiian/Other Pacific Islander

Are you Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Do you live alone? Yes No

If Yes, is your annual household income more than \$12,880? Yes No

If No, is your annual household income more than:

- If 2 people, is your annual household income more than \$17,420? Yes No
- If 3 people, is your annual household income more than \$21,960? Yes No
- If 4 people, is your annual household income more than \$26,500? Yes No
- If 5 people, is your annual household income more than \$31,040? Yes No
- If 6 or more people, is your annual household income more than \$35,580? Yes No

Are you interested in learning about other services that you currently are not receiving?

- Meals Transportation Nutrition Counseling Legal Assistance Caregiver Support
- Options to stay at home Options to return to home Health & Wellness Classes

Measure your Nutrition Risk!

1. Have there been any changes in your eating habits because of health problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you eat less than 2 meals a day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you eat few fruits, vegetables, or milk products?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you have 3 or more drinks of beer, wine, or liquor almost every day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you have a tooth or mouth problem that makes it hard to eat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you always have enough money to buy the food you need?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you eat alone most of the time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Do you take 3 or more different prescribed or over-the-counter drugs a day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you had unexpected weight gain or loss of 10+ pounds in the past 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Are there times you're physically unable to shop, cook, or feed yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. In the past 30 days, have you worried about whether your food would run out before you got money to buy more?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. In the past 30 days, did the food you buy just not last and you didn't have the money to buy more?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Do you feel lonely sometimes or often?	<input type="checkbox"/> Yes <input type="checkbox"/> No

This section to be completed by staff.

Service Received:

Congregate Nutrition

Health Promotion: Evidence Based

Health Promotion: Non-Evidence Based

Nutrition Counseling

Nutrition Education