INTAKE FORM

Date of Intake:	Intake By:	Start Date:

Last Name:	First Name:	Date of Birth:	Gender:	Marital Status: Single / Mar / Div / Sep / Wid

Street Address/Apartment Complex:	Phone:

Household Status:
- ❑ Lives Alone
- ❑ With Spouse
- ❑ With Relative
- ❑ With Minor Children
- ❑ With Non-Relatives
- ❑ Other

Housing Status: ❑ Homeowner ❑ Renter

Number in Household:

Household Income:

Insurance: ❑ Medicaid ❑ Medicare

Emergency Contact:	Relationship:	Emergency Contact Phone:

Social Isolation Score: How many people do you interact with per day? (Phone calls included)

❑ Less than 2 ❑ 3-5 ❑ 5+

Height:

Weight:

Veteran: ❑ Yes ❑ No

Spouse of Veteran: ❑ Yes ❑ No

Health History and Notes:

Means of Transportation:

❑ Own Car ❑ Family ❑ Friend ❑ Public Transportation ❑ Senior Transportation ❑ None

What days would you like Meals on Wheels delivered?

❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday ❑ Frozen Weekend

Would you like:

❑ Milk ❑ None

Diet Modifications & Food Allergies:

Do you have any of the following & how many?

___________ Cat(s) ____________ Dog(s)

Do you prefer:

❑ Wet food ❑ Dry food

Other Notes:

NUTRITIONAL SCREENING

Name:

	Please check the box to indicate your answer.	**YES**	**NO**	**POINTS**
1	I have an illness or condition that made me change the kind and/or amount of food I eat. (Do you restrict anything from your diet such as sugar, sodium, cholesterol, fat, potassium, or Vitamin K?)			**2**
2	I eat fewer than 2 meals per day.			**3**
3	I eat few fruits or vegetables. (Less than 5 servings, 1/2 cup is a serving.)			**1**
4	I eat/drink few milk products. (Less than 2 servings, 1 cup of milk or yogurt is a serving.)			**1**
5	I have tooth or mouth problems that make it hard for me to eat. (Do you have difficulty chewing any foods?)			**2**
6	I don't always have enough money to buy the food I need. (Do you have trouble stretching money at the end of the month or at different times of the year?)			**4**
7	I eat alone most of the time.			**1**
8	I take 3 or more different prescribed or over-the-counter drugs/medications a day. (Blood pressure, pain, laxatives, nerves, heart, insulin, sleep medications, aspirin, Tylenol, etc.)			**1**
9	Without wanting to, I have gained or lost 10 pounds in the last six months.			**2**
10	I am not always able to shop, cook, and/or feed myself. (Do you have or need a chore worker, friend, neighbor, or relative to help you shop, cook, or clean?)			**2**
11	I get less than 7-9 hours of sleep per night.			**2**
12	Do you feel meal services are or will be beneficial to you?			**0**
	Total the points for questions answered Yes.			

If your Nutritional Score is:

0 to2 Good! Recheck your nutritional score in 6 months.

3 to 5 You are at moderate nutritional risk. See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Recheck your nutritional score in 3 months.

6 & up You are at high nutritional risk. Bring this checklist the next time you see your doctor, dietician, or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.

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