Nutritional Program Intake

1. Personal Information: all information is required!
   1. Last Name 2. First name

Click here to enter last & first name

3. AKA First name.Click here to enter text.

4.-7.Physical Street Address, Town & Zip
Click here to enter text.

8. Is the client's mailing address the same as their residential address? ☐Yes ☐ No

8a.- 11. Mailing street address, town, state & zip
Click here to enter Mailing Address.

12. Date of birth _____/______/_____

13. Client's telephone #.Clck here to enter #.

14. What is the client's e-mail address?
Click here to enter text.

15. Gender: ☐ A - Male ☐B - Female ☐C - Other

16. Reason for needing meals (enter all that apply)
☐A - Hospital discharge
☐B - NH/Rehab
☐C - Unable to shop
☐D - Unable to cook
☐E - Homebound
☐F - Needs help with meal
☐G - Balance Issues/mobility issues
☐H - Visual
☐I - Other (describe in question notes)

16a. Other reasons for needing meals need
Click here to enter text.

16b. Length of service for meals
☐A - Short-term 0-6 weeks
☐B - Long-term
☐C - Unknown

17. Does the client have any of the following conditions/diagnoses?
☐A - Dementia
☐B - Depression
☐C - Congestive heart failure
☐D - COPD
☐E - Hip/knee replacement
☐F - Heart disease
☐G - Hypertension
☐H - Diabetes

18. Current living arrangement:
☐ Lives Alone ☐ Lives with others
☐C - Unknown

19. Are you a U.S. veteran?
☐A - Yes ☐B - No

20. Household Size	21.Monthly Income	
1 person	☐ $990 or below	☐above $990
2 person	☐$1335 or below	☐above $1335
3 person	☐$1680 or below	☐above $1680

22. Race (choose multiple)
☐A - Non-Minority (White,non-Hispanic)
☐B - White-Hispanic
☐C - American Indian/Native Alaskan
☐D - Asian
☐E - Black/African American
☐F - Hispanic
☐G - Native Hawaiian/Other PacificIslander
☐H - Other
☐I - Two or More Races
☐J - Unknown

23. Ethnicity?
☐A - Not Hispanic or Latino
☐B - Hispanic or Latino
☐C - Unknown

2. Emergency Contact Information

1. Emergency Contact Name:
Click here to enter text.

2. Relationship of Emergency Contact
Click here to enter text.

3. Day Phone of Emergency Contact
Click here to enter text.

4. E-mail primary emergency contact?
Click here to enter text.

5. Name of emergency Contact 2?
Click here to enter text.

6. Relationship to emergency contact 2

Click here to enter text.

7. Phone of emergency contact #2?
Click here to enter text.
8. email of secondary emergency contact?
Click here to enter text.

9. Primary care physician:
Click here to enter text.

10. Primary care physician phone number:
Click here to enter text.

3. Meal Information for meals delivery use

1. Meal Start date 1 _____/_____/_______

2. Meal End date 1 _____/______/_______

3. Meal End reason 1
☐A - Admitted to rehab or NH
☐B - Admitted to the hospital
☐C - Deceased
☐D - Didn't like the food
☐E - Got better
☐F - Moved
☐G - No longer need the meals
☐H - On Hospice
☐I - Other
☐J - Other dietary needs

4. Meal delivery days
☐ M ☐ T ☐ W ☐Th ☐ F ☐ S ☐ Su

5a. Number Breakfast meals: Click here to enter text.
5b. Number Bagged Suppers:Click here to enter #.
5c. Number of frozen meals: Click here to enter #.
5d. Number of Hot meals: Click here to enter #.

6. Total meals per weekClick here to enter #.

7. Meals Milk Type
☐1% ☐2% ☐skim ☐whole ☐No Milk

8. Dietary information
☐ Regular ☐ Diabetic ☐ Vegetarian ☐ Gluten free ☐ Low acid ☐F - Low fat/low cholestrol ☐ Low sodium ☐H - Lactose Intolerance

9. Meal Texture:
☐ Regular ☐ Ground ☐ Cut up ☐ Puree ☐ Soft ☐ Other

10. Describe the client's allergies, if any.

Click here to enter text.

Comments regarding Home Delivered Meals. Include options for meal choices.
Click here to enter text.

4. Delivery Information

1. Directions/Driver Notes:
Click here to enter text.
2. Do you have pets
☐ Yes ☐ No ☐Don't Know

3. Are pets controlled ☐ yes ☐ no

4. Does client drive a car ☐ yes ☐ no

5. Is client aware of referral: ☐ Yes ☐ No ☐ Client Not Cognizant

6. Name of person making Referral:
Click here to enter text.

7. Date of Referral
______/______/___________

8. Special notes
Click here to enter text.

5. Interviewer Check List

1. Meal Provider

2. Information taken by: Click here to enter text.

3. Date of the intake ____/______/_____

4. Did you explain: ☐ Donation policy ☐ Pet Policy ☐ 24 hr notice/cancellation policy ☐ Home assessment policy ☐ New Recipient package

6. Prioritization Questions

1. If you had groceries, would you be able to use them to prepare meals?
☐ A - Yes
☐ B - No

2. Do you have reliable help with meal preparation?
☐ A - Yes
☐ B - No

3. Are you able to get groceries into your home when you need them?

☐ A - Yes
☐ B - No

4. In the last twelve months, we worried whether our food would run out before we got money to buy more.☐ A - Yes
☐ B – No

5. In the last twelve months, the food we bought didn't last and we didn't have money to buy more.

☐ A - Yes
☐ B - No

Title: ______________________________ Date: ____________________