



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:				Zip Code:	
Email:		Phone:		Cell Phone:	
Ethnicity: <input type="checkbox"/> Hispanic or Latino		<input type="checkbox"/> Not Hispanic or Latino		Marital Status:	
Race: <input type="checkbox"/> White (Not Hispanic)		<input type="checkbox"/> Asian		<input type="checkbox"/> Married <input type="checkbox"/> Divorced	
<input type="checkbox"/> White (Hispanic)		<input type="checkbox"/> African American		<input type="checkbox"/> Single <input type="checkbox"/> Widowed	
<input type="checkbox"/> American Indian or Alaskan Native		<input type="checkbox"/> Other Race		<input type="checkbox"/> Legally Separated	
<input type="checkbox"/> Native Hawaiian or Pacific Islander		<input type="checkbox"/> Two or More Races		<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		Monthly Income: _____		<input type="checkbox"/> Lives Alone <input type="checkbox"/> Lives with Others	
If yes, specify language: _____		Below Poverty: <input type="checkbox"/> Yes <input type="checkbox"/> No		# 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 (circle points under Yes or No, then combine column totals)					
	Y	N		Y	N
I have an illness or condition that made me change the kind and/or amount of food I eat.	2	0	I don't always have enough money to buy the food I need.	4	0
I eat fewer than 2 meals per day.	3	0	I eat alone most of the time.	1	0
I eat few fruits and vegetables, or milk products.	2	0	I take 3 or more different prescribed or over-the-counter drugs a day.	1	0
I have 3 or more drinks of beer, liquor, or wine almost every day.	2	0	Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2	0
I have tooth or mouth problems that make it hard for me to eat.	2	0	I am not always physically able to shop, cook, and/or feed myself.	2	0
Totals			Totals		
Six or more points = High nutritional risk			Combined Column Totals: _____ /21 possible points		
Additional Nutrition Information					
Does client have difficulty swallowing: <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:		
UCLA 3-Item Loneliness Scale (check one response for each of the three questions)					
1. How often do you feel that you lack companionship?		<input type="checkbox"/> Hardly Ever	<input type="checkbox"/> Some of the Time	<input type="checkbox"/> Often	
2. How often do you feel left out?		<input type="checkbox"/> Hardly Ever	<input type="checkbox"/> Some of the Time	<input type="checkbox"/> Often	
3. How often do you feel isolated from others?		<input type="checkbox"/> Hardly Ever	<input type="checkbox"/> Some of the Time	<input type="checkbox"/> Often	
Other Contact Information					
Emergency Contact Name #1:			Daytime/Cell Phone:		
Emergency Contact Name #2:			Daytime/Cell Phone:		
Authorization of Release of Information					
<i>I give permission to the provider and/or the Area Agency on Aging Staff to discuss my needs.</i>					
Client Signature:			Date:		

Staff Person Initials: _____