YOUNG AT HEART RESOURCES
MEAL ASSESSMENT FORM

ASSESSING ORGANIZATION:_____DATE_____

CLIENT INFORMATION:

Last Name _____First Name_____MI_____Nickname_____

(ALWAYS USE BIRTHNAME FOR FIRST NAME NOT WHAT THEY GO BY)

Email_____Phone #_____Cell#_____

PRIMARY ADDRESS

House Number_____Street_____Apt/Suite/Building_____

City_____State_____Zip Code_____County_____

Rural: YES___NO___ Verified: YES___NO____ **(always make sure the address is verified for Aging IS)**

DEMOGRAPHIC INFORMATION

DOB:_____Social Security #_____ Gender_____

Ethnicity_____Primary Race_____ Household Income:_____ # In Household_____

Low Income: YES_____NO_____Primary Language_____

VETERAN

Veteran: YES_____NO_____ Spouse/Widow of Veteran_____Branch of Service_____

Year of Discharge_____Served During Wartime_____

OTHER

DCN#_____ Medicaid Eligible: YES_____NO_____

CONTACT INFORMATION (COMPLETE ADDRESS AND PHONE)

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone #: _____ Phone #: _____

Relationship: _____ Relationship: _____

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NUTRITIONAL RISK SCREEN (CHECK ONLY THE NUMBERS FOR A YES RESPONSE)

	YES	COMMENTS
1. I have an illness or condition that made me change the kind and amount of food I eat.	__	_____
2. I eat fewer than 2 meals per day.	__	_____
3. I eat few fruits and vegetables or milk products.	__	_____
4. I have 3 or more drinks of beer, liquor, or wine almost every day.	__	_____
5. I have tooth or mouth problems that make it hard for me to eat.	__	_____
6. I do not always have enough money to buy the food I need.	__	_____
7. I eat alone most of the time.	__	_____
8. I take 3 or more different prescribed or over-the-counter drugs a day.	__	_____
9. Without wanting to, I have lost or gained 10 pounds in the past 6 months.	__	Gain___Lost ___
10. I am not always physically able to shop, cook, and/or feed myself.	__	_____

Are you on a special/modified diet?_____

How many cups of water, milk or juice combined do you drink in a day?_____

Do you have any of the following that would affect your ability to eat?

___Choking ___ Swallowing___ Taste___ Nausea/vomiting___ Dentures lack of or ill fitting___Vision____None

Do you drive? YES_____NO_____ If you do not drive, how do you get to medical appointments, grocery shopping ETC._____
_____

Do you have any other concerns or needs that we might be able to help you with._____
_____
_____