NORTHWEST MISSOURI AREA AGENCY ON AGING
Congregate Meal Registration Form
SFY 2018

ASSESSING ORGANIZATION:_____DATE_____

CLIENT INFORMATION:

Last Name _____First Name_____MI_____Nickname_____

(ALWAYS USE BIRTH NAME 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_____ # In Household_____

Household Income:_____ 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_____

EMERGENCY CONTACTS

Name_____Address_____Phone #_____

Name_____Address_____Phone #_____

Name_____Address_____Phone #_____

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.	__	Gained___Lost___
10. I am not always physically able to shop, cook, and/or feed myself.	__	Which_____

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