

Center: FAIR LAWN

Client:
 First Name: _____
 Last Name: _____
 Address: _____
 City: _____
 Tel #: _____ - _____ - _____
 DOB: _____ / _____ / _____

Male
 Female

Emergency Contact:
 Name: _____
 Relation to Client: _____
 Tel #: _____ - _____ - _____
 Alt Tel #: _____ - _____ - _____
 Primary Physician: _____
 Physician's Tel #: _____ - _____ - _____

Check one:	
Hispanic/Latino	
Non-Hispanic	

Income per month: Check one

Single	\$973. or below	
Couple	\$1,311. or below	
Single	\$ 0 - \$1,800.	SFMNP 7/01/14- 6/30/15
Couple	\$ 0 - \$2,426.	
Single	\$ 0. - \$2,177.	PAAD
Couple	\$ 0. - \$2,669.	
Single	\$2,178. - \$3,010.	Senior Gold
Couple	\$2,670. - \$3,503.	
Single	\$3,011. or above	
Couple	\$3,504. or above	
	Unknown	

Check all that apply:	
White	
American Indian	
Black/African American	
Asian	
Pacific Islander	
Other	

Check each question below:	Yes	No
Lives alone		
Frail/ Disabled <i>Having a physical or mental disability that restricts the ability of an individual to perform normal daily tasks, or threatens the capacity of the individual to live independently.</i>		
Vulnerable <i>Exposed to unfavorable environmental conditions, or lack of social resources such as language barrier, isolation, no informal support system, income level between 100-200% of the poverty level, or not previously within the service system.</i>		

ADL/IADLS required for Home Delivered Meal clients only

Can you perform the following tasks by yourself without help (no impairment), or do you need help or supervision (impaired)?

ADL	No Impairment	Impaired	IADL	No Impairment	Impaired
Bathing			Preparing Meals		
Dressing			Laundry/Ordinary Housework		
Eating			Heavy Housework		
Getting out of bed/chair			Shopping		
Walking			Managing Medications		
Toileting			Using Transportation		
			Paying Bills/Managing Money		
			Using the Telephone		

Name _____ Date: _____

Determine Your Nutritional Health

The warning signs of poor nutritional health are often overlooked. Use this survey to find out if you are at nutritional risk.

Read the statements below. Circle the number in the column for those that apply to you. Total your nutritional score.

Today's Date: _____	Yes	No
1. I eat fewer than 2 meals a day; I mostly eat snacks or 1 complete meal a day.	3	0
2. I eat alone most of the time.	1	0
3. I eat less than 2 servings of milk or milk products most days; I eat 0-1 serving a day.	1	0
4. I eat less than 5 servings of fruit and/or vegetables most days.	1	0
5. I have 3 or more drinks of beer, liquor, or wine almost every day.	2	0
6. Without wanting to, I have lost or gained 10 pounds in the last 6 months. <input type="checkbox"/> lost or <input type="checkbox"/> gained	2	0
7. I have an illness or health condition (such as diabetes, high blood pressure, high cholesterol) that made me change the kind and/or amount of food that I eat.	2	0
8. I take 3 or more different prescribed or over-the-counter drugs every day.	1	0
9. I am not always physically able to shop, cook, or feed myself (or get someone to do it for me). Examples: I need help going food shopping, I need help cooking a meal, or I need help cutting up food on my plate. If 'Yes' to ANY OF THESE, circle 'Yes'.	2	0
10. I have problems with my teeth or mouth that make it hard to eat some foods.	2	0
11. I sometimes run out of money to buy the food that I need.	4	0
TOTAL		

Total your nutritional score. If it's

0-2 Good! Recheck your nutritional score in 6 months.

3-5 You are at moderate nutritional risk. See what can be done to improve your eating habits and lifestyle. Recheck your nutritional score in 3 months.

6 or more You are at high nutritional risk. Bring this survey the next time you see your doctor, or check the box below to speak with a registered dietitian free of charge.

Yes, I'd like to discuss this survey with a nutrition professional No, I'm not interested.

Male Female Height _____ Weight _____ (lbs) Tel. # (_____) _____

The best time to reach me is _____