CLIENT REGISTRATION FORM

Legal name (first/last): _____

Nickname: _____ ☐ Male ☐ Female

Date of birth: ____/____/____ Phone number: (____) _____

Physical address: _____ Mailing address: (if different) _____

☐ No current address/residence

EMERGENCY CONTACT INFORMATION:

Name 1 (first/last): _____ Relationship: _____

Home phone: (____) _____ Work or cell phone: (____) _____

Name 2 (first/last): _____ Relationship: _____

Home phone: (____) _____ Work or cell phone: (____) _____

ETHNICITY

☐ Hispanic or Latino

☐ Non-Hispanic or Latino

RACE

☐ White, Caucasian ☐ Hispanic

☐ American Indian/Alaskan Native

☐ Asian ☐ Black/African American

☐ Native Hawaiian or Other Pacific Islander

☐ Other _____

If you do not speak English, what is your primary language?_____

YOUR INCOME IS:

(The service provider will supply you with the current Federal Poverty Guidelines and 300% SSI amount.)

Please provide an answer on both lines:

☐ Below poverty **OR** ☐ Above poverty

☐ Below 300% SSI **OR** ☐ Above 300% SSI

DO YOU:

1. Live alone? ..... ☐ Yes ☐ No
2. Have a disability? ..... ☐ Yes ☐ No
3. Consider yourself frail? ..... ☐ Yes ☐ No

ARE YOU:

1. Unable to leave your home without assistance (homebound)? ..... ☐ Yes ☐ No
2. A veteran / served in armed forces? ..... ☐ Yes ☐ No
3. On state Medicaid? ..... ☐ Yes ☐ No
4. A Caregiver? ..... ☐ Yes ☐ No

IF YES, for whom do you provide care?

☐ Spouse ☐ Child, Age 0-18 ☐ Adult child, 18+

☐ Parent ☐ Family member ☐ Other _____

☐ I was provided the notice of privacy practices

_____ _____ _____ _____

Client Signature *(Initial or Revised Registration)* Date Client Signature – 2nd year Date

(I certify that my information has not changed.)

FOR OFFICE USE ONLY

Services Registered For: ***New to This Service?***

☐ _____ ☐ Y ☐ N

☐ _____ ☐ Y ☐ N

Nutrition Risk Assessment Score: _____

Client ID: _____

Site/Notes: _____

NUTRITION ASSESSMENT
This information is being collected for statistical purposes only.

Please check all that apply and determine your nutrition score

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

Nutrition Score _____

If your score is…

0 – 2 **Good!**

If it's…

3 – 5 **You are at moderate nutritional risk.**
See what can be done to improve your eating habits and lifestyle.

If it's…

6 or more **You are at high nutritional risk.**
Bring this check list the next time you see your doctor, dietitian or other qualified health or social service professional. Talk to them about any problems you may have. Ask them to help you improve your nutritional health.

_____ **I have been told by a medical professional that I am diabetic.**

_____ **I have been told by a medical professional that I have high blood pressure.**

Dining passes expire every year. Please register annually.