BURLINGTON COUNTY NUTRITION PROJECT FOR THE ELDERLY
PEMBERTON TOWNSHIP SENIOR CENTER
PARTICIPANT INTAKE FORM - CONGREGATE MEALS

NAME ______________________ REGISTRATION DATE ______________

ADDRESS ______________________ SEX: MALE ______ FEMALE ______

______________________ DATE OF BIRTH ______________

PHONE ______________________ MARITAL STATUS ______________

RACE:

White - Non-Hispanic ______
White - Hispanic ______
American Indian or Alaska Native ______
Asian ______
Black or African American ______
Native Hawaiian or Other Pacific Islander ______
Other ______
Multi-Racial ______
Unknown ______

ETHNICITY: Hispanic ______ Other ______ Unknown ______

MONTHLY INCOME: ______________

LIVING ARRANGEMENTS: Alone ______ Not Alone ______

(see reverse)

EMERGENCY INFORMATION:

NAME ______________________ PHYSICIAN ______________________

ADDRESS ______________________ ADDRESS ______________________

______________________ ______________________

PHONE ______________________ PHONE ______________________

RELATIONSHIP TO PARTICIPANT ______________________

MEDICAL PROBLEMS:

HEART ______ DIABETIC ______

OTHER ______________________

____

ALLERGIC TO ANY MEDICATIONS

LIST: ______________________

____

____

DO YOU HAVE ANY FAMILY OR CLOSE FRIENDS IN THE AREA? Yes______ No______
WHAT ARE THEIR NAMES AND HOW ARE THEY RELATED TO YOU?

Relative/Person #1:______________________ How Related?
Phone:

Relative/Person #1 ______________________ How Related?
Phone:

WHAT CHURCH DO YOU BELONG TO? ______________________ PHONE NUMBER

NUTRITIONAL SURVEY

** Read the statements below. Check the appropriate answer.*	Yes	No	Score
1. Do you eat <u>less</u> than two (2) meals a day?			3
2. Do you eat alone most of the time?			1
3. Do you consume <u>less</u> than two (2) servings of milk or milk products in your daily diet? If yes, why? ______________________			1
4. Do you eat <u>less</u> than five (5) servings of fruits and/or vegetables each day?			1
5. Do you have three (3) or more drinks of beer, liquor or wine every day?			3
6. Have you gained 10 pounds or more in the last six months without wanting to?			2
7. Have you lost 10 pounds or more in the last six months without trying to?			2
8. Do you have a health problem or illness that makes you change the kind and/or amount of food you eat? If yes, please specify: ______________________			2
9. Do you take three (3) or more different prescribed or over-the-counter drugs in a day?			1
10. Do you need assistance, most of the time, with these daily activities? Please check: _______ food shopping _______ meal preparation _______ eating			2
11. Do you have tooth or mouth problems that make it hard for you to eat?			2
12. Do you sometimes run out of money to buy food that you need?			4
_______ Age _______ Male _______ Female _______ Height _________ Current Weight **Survey Total**			

** After completing the survey, would you like to discuss this with someone?* _____ ***YES*** _____ ***NO***

__________ ***Score*** _______ ***Good*** _______ ***Moderate*** _______ ***High***

Name______________________________ **Date**__________ **Phone No.**____________________