Blount Community Action Agency Senior Nutrition- Meals on Wheels- Intake Questionnaire

Date:_____ _____

Clients Name:_____Gender:_____

Address:_____

Phone Number:_____ last 4 digits social security:_____

Date of Birth:_____ _____Current Age:_____

Do you have a caregiver: _____Who?_____

Nearest Relative:_____Phone:_____

Current Living Arrangement:_____ ex: self, w/spouse

Type of Residence: _____(home, apartment, mobile home)

Any family in the area?:_____ Who shops/cleans?:_____

Rate your health (1=poor- 10 =great):_____

Any overnight stays in the hospital in past year?_____ any falls?_____

Mobility: (walker, wheelchair, cane)_____

Any vision/hearing impairments?_____How many daily medications:_____

How many meals eaten a day?_____ Do you often eat alone?_____ _____

Weight loss or gain last 6 months (10 + lbs)_____

Can you prepare meals if not can someone help?_____

Are you getting enough help at home?_____

Do you have memory problems:_____

Do you have problems making people understand you?_____

Monthly Income and source:_____

Do you receive any help with your Medicare premiums? _____

Have you applied for Options or Choices:_____

- ***Please use other side of Page to describe general health and struggles or special diets***