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

Date: _____ **OFFICE USE ONLY: DATE REC'D: _____**

Client's Name: _____ Gender:_____

Address:_____City:_____ Zip:_____

Phone: _____ Cell:_____ Date of Birth: _____

Last 4 digits of Social Security Number:_____ Current Age:_____

Nearest Relative: _____ Phone: _____ Cell: _____

Current Living Arrangement: _____ (EX: self, with spouse, with children, etc.)

Type of Residence: _____ (EX: home, apt., mobile home, etc.)

Can you prepare meals if no one can help (yes/no): _____

Can you use a microwave (yes/no): _____

Do you have enough food at the end of the month (yes/no): _____

Do you get food from any of the food pantries (yes/no): _____ Which one: _____

Difficulties in eating (yes/no): _____ Diet restrictions/diabetic (yes/no): _____

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

Any overnight stays in hospital or rehab in the past year(yes/no): _____

Any falls(yes/no): _____ Mobility (cane, walker, wheelchair): _____

Any vision/hearing/speech impairments (yes/no):_____ Do you have memory problems (yes/no): _____

How many medications do you take a day (including over-the-counter): _____

How many meals do you eat a day: _____ Do you often eat alone(yes/no):_____

Weight loss/gain (10 + lbs.) in the last six months (yes/no): _____

Are you getting enough help at home (yes/no): _____ Are you a veteran (yes/no):_____

Do you have a problem with people understanding you (yes/no): _____

Monthly income: Social Security: $_____ SSI: $_____ Retirement: $_____

What was your occupation: _____Have you applied for OPTIONS or CHOICES (yes/no): _____

Please use the back of this sheet to describe general health and struggles.

*****NOTE: THIS IS MANDATORY TO PRIORITIZE YOUR NEED FOR MEAL SERVICES*****

Please Use This Page To Describe General Health And Struggles