

# Congregate Meals Intake

Date \_\_\_\_\_

Proper completion of this form will have an impact on the money allocated for services

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Email Address \_\_\_\_\_

**Gender:**     Male     Female

**Ethnicity:**     Not Hispanic/ Latino     Hispanic or Latino

**Race:**     White– Non Hispanic     White– Hispanic  
 Black/ African American     American Indian/ Native Alaskan  
 Asian     Native Hawaiian/ Pacific Islander

**Primary Language:**     English     Spanish     Other

**US Citizenship:**     Male     Female

**Marital Status:**     Married     Single     Divorced     Other

**Do You Live:**     Alone     With Spouse     With Family     With Non-Relative  
 Other     Not Disclosed

| Nutritional Health  | Yes | No |
|---|-----|----|
| I have an illness or condition that causes me to change the amount and/or kind of food I eat. |     |    |
| I eat fewer than 2 meals per day.   |     |    |
| I eat few fruits or vegetables a day.   |     |    |
| I eat or drink few milk products (milk, yogurt, cheese) a day                                 |     |    |
| I don't always have enough money to buy food  |     |    |
| I have tooth or mouth problems that make it hard for me to eat.                               |     |    |
| I eat alone most of the time.   |     |    |
| I have involuntarily lost or gained 10 pounds in the last six months                          |     |    |
| I am not always physically able to shop, cook and/or feed myself                              |     |    |
| I have 3 or more drinks of beer, wine or liquor almost every day                              |     |    |
| I take 3 or more different prescription or over-the-counter medications a day                 |     |    |