CONSUMER INFORMATION ASSESSMENT - Boulder County Area Agency on Aging – 2/12/2013

Last Name:_____ **First Name:**_____ **Middle Initial:**_____

Gender: M / F **Birth Date:**_____ **Age:**_____ **Last 4 Digits of Your Social Security Number:** XXX-XX-____ ____ ____ ____

Do you consider yourself Hispanic or Latino? Yes / No **Race:**_____ **Primary Language:**_____

Monthly Income:

Single	**Married**
_____$958 or less	_____$1,293 or less
_____$959-$1,197	_____$1,294-$1,616
_____$1,198-$1,771	_____$1,617-$2,391
_____$1,772 or more	_____$2,392 or more

Are you a Veteran: Yes / No

Program: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ☐

Employment: Full-Time ☐ Part-Time ☐ Temporary Jobs ☐ Not Employed ☐

Vision Problems: Yes / No Do you wear eyeglasses? Yes/No

Hearing Problems: Yes / No Do you wear a hearing aid? Yes / No

E-mail: _____

Street Address:_____ **Telephone:**_____

City:_____ **State:**_____ **Zip Code:**_____

Living alone ☐ Living with extended family ☐

Living with spouse or partner ☐ Living with non-relatives ☐

Owns Home ☐ Assisted Living ☐

Rents Home/Apartment ☐ Homeless ☐

Family member's residence ☐ Other ☐

Emergency Contact Name:_____ **Relationship:**_____ **Telephone Number:**_____

Primary Physician Name: _____ **Physician's Phone Number:** _____

I have been informed of the policies regarding voluntary contributions, complaint procedures, and appeal rights.

Signature_____ Date_____

Nutrition Checklist	**Y**	**N**	**Score**
I have an illness or health condition that made me change the kind and/or amount of food I eat.			2
I eat fewer than 2 meals per day.			3
I eat few (two or less servings) fruits, vegetables, or milk products a day.			2
I have 3 or more drinks of beer, wine, or liquor almost every day.			2
I have tooth or mouth problems that make it hard for me to eat.			2
I don't always have enough money to buy the food I need.			4
I eat alone most of the time.			1
I take 3 or more different prescribed or over the counter drugs a day.			1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.			2
I am not always physically able to shop, cook, and /or feed myself.			2

If answer is "yes," circle the score. Add the scores to determine your total nutritional score.

(0-2=No Risk 3-5= Moderate Nutritional Risk 6 or More=High Nutritional Risk) **Total "Yes" Score: _____**

Would you like to be contacted by a registered dietitian? _____ Yes _____ No

Activities of Daily Living (ADLs)	**Y**	**N**
I can eat without help.	☐	☐
I can dress myself without help.	☐	☐
I can bathe myself without help.	☐	☐
I can use the toilet without help.	☐	☐
I can get in and out of the bed/chairs without help.	☐	☐
I can get around inside my home without help.	☐	☐

Instrumental Activities of Daily Living (IADLs)	**Y**	**N**
I can manage money without help.	☐	☐
I can take care of shopping without help.	☐	☐
I can take my medication without help.	☐	☐
I can prepare meals without help.	☐	☐
I can do ordinary housework without help.	☐	☐
I can use the telephone without help.	☐	☐
I can use transportation without help.	☐	☐

Are you currently receiving assistance with ADLs or IADLs from anyone? Yes / No

If yes, from whom are you receiving assistance with ADLs and/or IADLs? _____

For Office Use Only:

	Y	**N**
Does the consumer require a home health aide based on orders from a physician?	☐	☐
Can the consumer perform chore/heavy housework without help?	☐	☐

Comment on the consumer's inability to perform chore services:

_____

	Y	**N**
Does the consumer reside in a rural area?	☐	☐
Is the consumer homebound?	☐	☐
Is the consumer geographically isolated?	☐	☐

What is the consumer's level of cognitive functioning?

Alert/oriented ☐

Requires considerable assistance in routine situations ☐