 **Client Information Assessment**

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| **Data Entry Workflow:** Region 3B – BCAAA – Congregate Meals | **Application Date:** |
| **Event Profile:** Nutrition Counseling – BNE  |
| **Demographics** |
| **Last Name:** | **First Name:** | **Gender:** | **DOB:** |
| **Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Email Address:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Are you a U.S. Veteran?** YES NO**Do you live alone?**  YES NO**What is your preferred language?** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Do you identify as:** *(Please select one)** American Indian
* Asian
* Black/African American
* Hispanic/Latino
* Native Hawaiian or other Pacific Islander
* White, non-Hispanic
* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
 | **Are you visually impaired?***(cannot be corrected with glasses)* YES NO**Monthly income range -*Individual***:*(if applicable)** $1,041 or less
* $1,042 to $1,301
* $1,302 to $1,926
* $1,927 or more

**Monthly income range -*Married*:** *(if applicable)** $1,409 or less
* $1,410 to $1,761
* $1,762 to $2,607
* $2,608 or more

**Boulder County residents 60+ are eligible for 2 Nutrition Counseling sessions at no cost. Would you like to learn more?** YES NO |

**I have been informed of the Boulder County Area Agency on Aging’s policies regarding voluntary contributions, complaint procedures, and appeals rights. I am aware that in order to receive requested services, it may be necessary to share information with other BCAAA programs or contracted service providers and I herewith give my consent to do so.**

*Staff: Initial here if consent to share information is* ***NOT*** *given by the client. \_\_\_\_\_\_\_\_*

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Nutrition Checklist |
| If answer is ‘Yes’, circle the #. Add the #s to determine total nutritional score. |  |  | **#** |
| I have an illness or condition that made me change the kind and/or amount of food I eat. | YES | NO | 2 |
| I eat less than 2 meals per day. | YES | NO | 3 |
| I eat few fruits or vegetables or milk products. | YES | NO | 2 |
| I have 3 or more drinks of beer, liquor, or wine almost every day. | YES | NO | 2 |
| I have tooth or mouth problems that make it hard for me to eat. | YES | NO | 2 |
| I don’t always have enough money to buy the food I need. | YES | NO | 4 |
| I eat alone most of the time. | YES | NO | 1 |
| I take 3 or more different prescribed or over the counter drugs a day. | YES | NO | 1 |
| Without wanting to, I have lost or gained 10 pounds in the last 6 months. | YES | NO | 2 |
| I am not always physically able to shop, cook and/or feed myself.  | YES | NO | 2 |
| *0-2 = No Risk 3-5 = Moderate Risk 6 or more = High Risk* | Total ‘#’:**\_\_\_\_\_\_**  |
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