ORANGE COUNTY OFFICE FOR THE AGING SENIOR DINING PROGRAM

CONGREGATE (OVER 60) REGISTRATION

Please "√"

☐BLOOMING GROVE ☐CORNWALL ☐HIGHLAND FALLS ☐HAMASPIK
☐MONTGOMERY ☐MIDDLETOWN ☐GREENWOOD LAKE

PARTICIPANT INFORMATION

NAME____ *** DATE OF BIRTH_____________________ ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ LEGALLY SEPARATED

SOCIAL SECURITY #:_______________________________ PHONE/CELL PHONE: _____________________________

ADDRESS:____
(STREET) (CITY) (STATE) (ZIP)

APARTMENT NAME _________________________________ APT. NUMBER _____________

MAILING ADDRESS (IF DIFFERENT) ____

EMERGENCY CONTACT INFORMATION

(1) NAME____ RELATIONSHIP______________________

ADDRESS: ____

HOME PHONE: (_______)__________________________ WORK/CELL PHONE: (_____) ______________________

(2) NAME____ RELATIONSHIP______________________

ADDRESS: ____

HOME PHONE: (_______)__________________________ WORK/CELL PHONE: (______)_______________________

PHYSICIAN:____ ADDRESS: ______________________________________

____

PHONE: ________________________

FOR STATISTICAL PURPOSES WE NEED THE FOLLOWING INFORMATION

Do you live alone? ☐Yes ☐No IF NO, how many people in your household? _______
With whom? ☐Spouse ☐Family ☐Friend ☐Group Home

Are you disabled/frail? ☐Yes ☐No

Please estimate your yearly income (based on your income you may be eligible for additional programs and services) $_________________ PER YEAR ☐ Refused

Are you a veteran? ☐Yes ☐No Are you a Spouse of a veteran? ☐Yes ☐No

Please indicate your ethnicity: ☐Non-Minority (White) ☐African American ☐Hispanic Origin ☐Asian ☐American Indian/Alaskan Native ☐Native Hawaiian or other Pacific Islander

***PARTICIPANT SIGNATURE____ ***DATE _______________

Participant's Name ___________________________________

****REQUIRED NUTRITION INFORMATION FOR NUTRITIONAL COUNSELING****

Current Weight ______ **Height**_____ **Recent weight changes:** (+) or (-) _____ lbs in past 6 Months

TYPE OF DIET: ☐Regular (No Salt Added) ☐Diabetic ☐Low Sodium Other___________________

Food Allergies (not likes and dislikes): ☐None ☐Chocolate ☐Citrus ☐Dairy ☐Egg ☐Fish ☐Peanuts/Nuts ☐Shellfish ☐Tomato ☐Wheat/Gluten ☐Other________________

Meat Consistency: ☐Whole ☐Cut-up ☐Ground

******Nutrition Risk Score Screening******

Please "√" "YES" or "NO" to the following questions:

For the questions below, write the corresponding number of points in the score box for each "Yes" response.

	Y	N		SCORE
Have you made any changes in lifelong eating habits because of health problems?			**2**	
Do you eat fewer than 2 meals per day?			**3**	
Do you eat few (less than 5) vegetables or fruits, or milk products per day?			**2**	
Do you have 3 or more drinks of beer, liquor or wine almost everyday?			**2**	
Do you have trouble eating well due to problems with chewing/swallowing?			**2**	
Is your ability to buy nutritious foods limited because you do not have enough money or food stamps to buy the food you need?			**4**	
Do you eat alone most of the time?			**1**	
Do you take 3 or more prescribed or over-the-counter drugs a day?			**1**	
Have you lost or gained 10 pounds in the past 6 months?			**2**	
Are you ***not*** always physically able to shop, cook, and/or feed yourself, (or get someone to do it for you)?			**2**	
TOTAL SCORE FOR NUTRITION SCREEN:				

For office use only: Nutritional Risk Status:

☐ **High (score of 6 or more)** ☐ **Moderate (score 3-5)** ☐ **Low (2 or less)**

**** High Risk Scores should be referred to the RD for nutrition assessment/diet education****

Nutrition/Medical History: Please "√" "YES" or "NO" to the following questions:	Y	N
Do you have a recent history of an **eating disorder** like anorexia and or bulemia?		
Do you have a recent history of **treatment for cancer** requires chemotherapy or radiation that is interfering with your appetite?		
Do you have a recent history of **colitis** that requires that your diet be restricted?		
Do you have **edema or swelling** of your legs or feet?		
Do you have **diabetes** that has not been addressed by a dietitian or nutritionist?		
Do you have **digestive problems** that limit the amount and/or kind of foods that you can eat?		
Have you had a **heart attack** or stroke that has not been addressed by a dietitian or nutritionist?		
Do you have **high blood pressure** that is not well controlled with medication or a low salt diet?		
Do you have trouble **swallowing** that limits your food or liquid intake?		
Do you have a history of **high cholesterol** that requires education about a diet?		
Do you have a history of **liver disease** that requires a change in diet?		
Do you have a history of **kidney disease** that requires education?		
Do you need **nutrition education** that you would like to speak to a dietitian about? Specify:		

For office use only: ☐ Data Entered _______________

☐ Copy Sent To Site _____________