Iowa Department on Aging - Aging & Disability Network Consumer Intake Form

Date: _____ / _____ / _____ ☐ New ☐ Update

Consumer Last Name: _____ First: _____ MI _____

Date of Birth: _____ / _____ / _____ or Age: _____

Address: _____ City: _____ State _____ Zip: _____

Phone: ( ) _____ - _____ Gender: [ ] Male [ ] Female

Race: ☐ White ☐ American Indian/Alaskan Native ☐ Asian
☐ African American/Black ☐ Native Hawaiian/Other Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Do you live alone? ☐ Yes ☐ No Number in Household: _____

Please Check Your Annual Total Household Income Range:

☐ $0 - $11,490	☐ $11,491 - $15,510	☐ $15,511 - $19,530
☐ $19,531- $23,550	☐ $23,551 - $27,570	☐ $27,571 - $31,590
☐ $31,591- $35,610	☐ $35,611 - $39,630	☐ $39,631 - or Above

Activities of Daily Living (ADL)
Can You Without Assistance:

☐ Yes ☐ No Walk?
☐ Yes ☐ No Bathe?
☐ Yes ☐ No Dress?
☐ Yes ☐ No Get out of bed or chair?
☐ Yes ☐ No Use the Toilet?
☐ Yes ☐ No Eat?

Instrumental Activities of Daily Living (IADL)
Can You Without Assistance:

☐ Yes ☐ No Manage money?
☐ Yes ☐ No Shop for personal items?
☐ Yes ☐ No Manage medication?
☐ Yes ☐ No Prepare meals?
☐ Yes ☐ No Do heavy housework?
☐ Yes ☐ No Do light housework?
☐ Yes ☐ No Use transportation?
☐ Yes ☐ No Use the telephone?

Provider / Site: _____ _____

Select Registered Service Provided

☐ Adult Day Care /Day Health	☐ Congregate Meals	☐ Nutrition Counseling
☐ Assisted Transportation	☐ Health Promotion	☐ Nutrition Education
☐ Case Management	☐ Home Delivered Meals	☐ Personal Care
☐ Chore	☐ Homemaker	

Complete the Nutrition Risk Assessment on the reverse side of this form if receiving Home Delivered Meals or Congregate Meals or Nutrition Counseling or Case Management.

Revised Date: 6/18/2013

Nutrition Risk Screening

(Home Delivered Meals, Congregate Meals, Nutrition Counseling and Case Management Services Only)

Provider / Site: _____

Consumer Last Name: _____ **First:** _____ **MI** _____

☐ **Yes** ☐ **No** I have an illness or condition that made me change the kind and/or amount of food I eat.

☐ **Yes** ☐ **No** I eat fewer than two meals per day.

☐ **Yes** ☐ **No** I eat few fruits. (Less than $1^{1/2}$ cups daily)

☐ **Yes** ☐ **No** I eat few vegetables. (Less than 2 cups daily)

☐ **Yes** ☐ **No** I eat and/or drink few milk products. (Less than 3 cups daily)

☐ **Yes** ☐ **No** I have three or more drinks of beer, liquor or wine almost every day.

☐ **Yes** ☐ **No** I have tooth or mouth problems that make it hard for me to eat.

☐ **Yes** ☐ **No** I don't always have enough money to buy the food I need.

☐ **Yes** ☐ **No** I eat alone most of the time.

☐ **Yes** ☐ **No** I take 3 or more different prescribed *or* over-the-counter drugs a day.

☐ **Yes** ☐ **No** I have lost or gained 10 pounds in the last 6 months, without wanting to.

☐ **Yes** ☐ **No** I am ***not*** always physically able to do ***one or more*** of: shopping, cooking or feeding myself.