

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

Date Completed: _____ 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:

- | | | |
|--|--|--|
| <input type="checkbox"/> \$0 - \$11,670 | <input type="checkbox"/> \$11,671 - \$15,730 | <input type="checkbox"/> \$15,731 - \$19,790 |
| <input type="checkbox"/> \$19,791 - \$23,850 | <input type="checkbox"/> \$23,851 - \$27,910 | <input type="checkbox"/> \$27,911 - \$31,970 |
| <input type="checkbox"/> \$31,971 - \$36,030 | <input type="checkbox"/> \$36,031 - \$40,090 | <input type="checkbox"/> \$40,091 - or Above |

Activities of Daily Living (ADL)

Without Assistance Can You:

- | | | |
|--------------------------|------------------------------|-----------------------------|
| Walk? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bathe? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dress? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Get out of bed or chair? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Use the toilet? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Eat? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Instrumental Activities of Daily Living (IADL)

Without Assistance Can You:

- | | | |
|--------------------------|------------------------------|-----------------------------|
| Manage money? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shop for personal items? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Manage medication? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Prepare meals? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do heavy housework? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do light housework? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Use transportation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Use the telephone? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Provider / Site: _____

Select Registered Service Provided

- | | | |
|---|---|---|
| <input type="checkbox"/> Adult Day Care /Day Health | <input type="checkbox"/> Congregate Meals | <input type="checkbox"/> Nutrition Counseling |
| <input type="checkbox"/> Assisted Transportation | <input type="checkbox"/> Health Promotion | <input type="checkbox"/> Nutrition Education |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Home Delivered Meals | <input type="checkbox"/> Personal Care |
| <input type="checkbox"/> Chore | <input type="checkbox"/> Homemaker | <input type="checkbox"/> Options Counseling |

Special Instructions: Complete the *Nutrition Risk Screening* form if individual above is receiving Home Delivered Meals, Congregate Meals, Nutrition Counseling or Case Management. 

Iowa Department on Aging - Nutrition Risk Screening

Complete this form for individuals receiving Home Delivered Meals, Congregate Meals, Nutrition Counseling, and Case Management Services only.

Provider / Site: _____

Date Completed: _____

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 ½ 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.