CLIENT REGISTRATION FORM

LEGAL NAME (First/Last): _____

NICKNAME: _____ GENDER: ☐ MALE ☐ FEMALE

DATE OF BIRTH: _____ PHONE NUMBER: (_____)_____

ADDRESS: _____
Street **(City, State, Zip Code)**

MAILING ADDRESS (If different): _____
Street **(City, State, Zip Code)**

☐ No Current Address/Residence

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____

HOME PHONE: (_____)_____ WORK/CELL PHONE: (_____)_____

ETHNICITY

☐ HISPANIC OR LATINO
☐ NON-HISPANIC OR LATINO

RACE

☐ WHITE/CAUCASIAN ☐ ASIAN
☐ BLACK/AFRICAN AMERICAN
☐ AMERICAN INDIAN/ALASKA NATIVE
☐ NATIVE HAWAIIAN/PACIFIC ISLANDER
☐ OTHER:_____

LANGUAGE

☐ ENGLISH ☐ SPANISH
☐ OTHER: _____

YOUR INCOME IS*:

☐ BELOW POVERTY **or** ☐ ABOVE POVERTY
(select one)
*See back of form for income guidelines

DO YOU?

LIVE ALONE? ☐ YES ☐ NO

ARE YOU?

UNABLE TO LEAVE YOUR HOME WITHOUT ASSISTANCE (Homebound)? ☐ YES ☐ NO

A VETERAN/SERVED IN ARMED FORCES?
☐ YES ☐ NO

Activities of Daily Living (ADLs)
I am UNABLE to perform, without assistance:

☐ Bathe ☐ Eat ☐ Walk ☐ Get Dressed
☐ Use Bathroom ☐ Transfer in/out of bed or chair
☐ **None (I can perform above tasks)**

Instrumental Activities of Daily Living (IADLs)
I am UNABLE to perform, without assistance:

☐ Prepare meals ☐ Take medication ☐ Shop
☐ Manage money ☐ Do light housework
☐ Do heavy housework ☐ Use the telephone
☐ Use transportation services
☐ **None (I can perform above tasks)**

☐ I was provided the "*Notice of Privacy Practices*"

Client Signature: _____ **Date: _____**

Turn Over to Complete

CLIENT REGISTRATION FORM

Determine Your Nutritional Health

Circle each that applies to your nutritional habits	
1. I have an illness or condition that made me change the kind and/or amount of food I eat.	2 points
2. I eat fewer than 2 meals per day.	3 points
3. I eat few fruits or vegetables, or milk products.	2 points
4. I have 3 or more drinks of beer, liquor, or wine almost every day.	2 points
5. I have tooth or mouth problems that make it hard for me to eat.	2 points
6. I don't always have enough money to buy the food I need.	4 points
7. I eat alone most of the time.	1 point
8. I take 3 or more different prescribed or over-the-counter drugs a day.	1 point
9. Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2 points
10. I am not always physically able to shop, cook and/or feed myself.	2 points
Please Total Your Nutritional Score	

If your score is

0-2 **Good! Recheck your nutritional score in 6 months.**

3-5 **You are at moderate nutritional risk.**

See what can be done to improve your eating habits and lifestyle. Refer to the attached handout for helpful tips. Recheck your nutritional score in 3 months.

6+ **You are at high nutritional risk.**

Bring this checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
2022 FEDERAL POVERTY GUIDELINES

Size of Family Unit	Federal Poverty Guidelines 48 Contiguous States and D.C.	
	Annual Income	Monthly Income
1	$13,590	$1,135.50
2	$18,310	$1,525.83
3	$23,030	$1,919.16
4	$27,750	$2,312.50

Print Name: _____ **Date:** _____