ENOA Diner's Choice Intake Information

Gender *(Circle one)* **Female** **Male**

Date: _____

***Name:** _____ ***Date of Birth:**_____

***Address** _____

***Town** _____ ***Zip** _____ ***Phone Number**_____

***Race:**

_____American Indian/Alaska Native
_____Asian
_____Black/African American
_____Hispanic or Latino
_____Native Hawaiian/Pacific Island
_____White

***Ethnicity**:

_____Hispanic or Latino
_____Not Hispanic or Latino
_____No response

***Monthly Income (Circle one)**

Single person above $ 1,304.16_ Yes No
Married couple above $ 1,762.50 Yes No

***Participant status for meals:**

_____60+ Person

_____Less than 60 spouse of 60+ person

_____Less than 60 disabled person residing with 60+ Person

***Lives with:**

_____Alone
_____In a group setting
_____With other family/friends
_____With spouse

***Marital Status: (Circle one)** Single Married Divorced Widow/Widower

***Emergency Contact:** (Please include name & phone number)_____

_____

***ALL "BOLD AREAS" ARE MANDATORY AND MUST BE COMPLETED**

***Please circle Yes or No to the following questions:**

Has an illness or medical condition made you change the way you eat? ..... Yes No
Do you eat fewer than 2 meals a day? ..... Yes No
Do you eat less than one serving of milk or fruits and vegetables a day? ..... Yes No
Do you drink 3 or more glasses of beer, liquor, or wine every day? ..... Yes No
Do you have problems with your teeth or mouth that make it hard to eat? ..... Yes No
Do you have enough money to buy the food you need? ..... Yes No
Do you eat alone most of the time? ..... Yes No
Do you take 3 or more different prescription or over the counter drugs daily? ..... Yes No
Have you gained or lost more than 10 pounds in the last 6 months without wanting to? ..... Yes No
Are you able to do your own grocery shopping and cooking? ..... Yes No

Release of Information: I consent to the release of information in this document so I can receive services. I understand the information in this document will be released to the Eastern Nebraska Office on Aging, and service providers as listed to enable the delivery of services and program monitoring.

Customer/Guardian Signature_____ Date _____