

**NAPIS NUTRITION REGISTRATION FORM**

SUBMIT BY THE 10<sup>TH</sup> OF EACH MONTH  
TO THE WESTCHESTER COUNTY DEPARTMENT OF SENIOR PROGRAMS & SERVICES: COUNTY CODE 55

Provider Name: \_\_\_\_\_

Program Site: \_\_\_\_\_

Intake Date: --

Date of Birth: --

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Init: \_\_\_\_\_

Address \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Tel: \_\_\_\_\_

Gender:  Male  Female Lives Alone:  Yes  No Veteran:  Yes  No

Marital Status:  Married  Widowed  Single / Never Married  Divorced

Number in Household: \_\_\_\_\_ Ethnicity:  Hispanic  Non-Hispanic  Unknown

Race:  White  Black  Amer. Indian/Alaskan  Asian  Nat. Hawaiian/Pacific Is.  Hispanic/Latino

Income Status: 100%

150%

Enter "No" on Status

Monthly Income:	Family Size = 1:	Less Than \$ 817	<input type="checkbox"/>	Less Than \$1,225	<input type="checkbox"/>	More Than \$1,225	<input type="checkbox"/>
	Family Size = 2:	Less Than \$ 1,100	<input type="checkbox"/>	Less Than \$1,650	<input type="checkbox"/>	More Than \$1,650	<input type="checkbox"/>
	Family Size = 3:	Less Than \$ 1,384	<input type="checkbox"/>	Less Than \$2,500	<input type="checkbox"/>	More Than \$2,500	<input type="checkbox"/>

Frail/Disabled:  Yes  No

Medical or Emergency Contact Information:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Tel: \_\_\_\_\_ Business Tel: \_\_\_\_\_

Physician: \_\_\_\_\_ Tel: \_\_\_\_\_

Medical Conditions: \_\_\_\_\_

Are you taking any prescribed medicine?:  Yes  No Please List Medications: \_\_\_\_\_

Special Dietary Needs:  No  Regular Diet Without Added Salt  Low Cholesterol/Low Fat  Diabetic

Other: Please Specify: \_\_\_\_\_

Do you have a food allergy? :  No  Yes If Yes, Specify Below: \_\_\_\_\_

Are you allergic to any medication?:  No  Yes If Yes, Specify Below: \_\_\_\_\_

Do you require assistance with grocery shopping?  Yes  No

Primary Language if Not English: \_\_\_\_\_

How do you generally expect to get to this site:  Walk  Drive Own Car  Ride with Friend  
 Public Transportation  Nutrition Site Transportation

**Services:**  III C 1 - Congregate Meals  III C 1 - Nutrition Education  
 SNAP - Congregate Meals (Only Yonkers)  III B - Nutrition Site Transportation  
 III B - Information & Assistance (Only Mt. Vernon, New Rochelle, Yonkers)  III B - Supportive Services Transportation IF Received at Nutrition Site

Please answer the following nutrition questions. Total all the "Yes" responses and add up score; review the nutritional health results below.

	If YES Circle #		
Do you eat fewer than 2 meals per day?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	3
Do you have an illness or condition that made you change the kind and/or amount of food eaten?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	2
Do you eat fewer than 2 ½ cups of fruit or vegetables daily?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	1
Do you eat fewer than 2 servings of dairy products daily?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	1
Do you have 3 or more drinks of beer, liquor or wine daily?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	2
Do you eat alone most of the time?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	1
Do you have trouble eating due to problems with chewing/swallowing?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	2
Do you sometimes have problems buying food because of income?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	4
Do you take 3 or more different prescribed or OTC drugs daily?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	1
Without wanting to, have you lost or gained 10 pounds in the past 6 months?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	2
Are you not always physically able to shop, cook and/or feed yourself?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	2

**TOTAL** \_\_\_\_\_

**NUTRITIONAL HEALTH SCORE RESULTS SCORE**

- 0 - 2 Good Nutritional Health; Recheck at 6 Months.
- 3 - 5 Moderate Nutritional Risk; Need to see what can be done to improve eating habits and make life-style changes.
- 6 + High Nutritional Risk; Take checklist to a doctor, dietitian or qualified health or social service professional; talk to them and ask for definite ways to improve nutritional health.

I GIVE PERMISSION TO THE NUTRITION PROGRAM TO CONTACT MY PHYSICIAN OR OTHER MEDICAL PERSONNEL IN CASE OF AN EMERGENCY. THE DATA PROVIDED THROUGH THIS FORM WILL BE TREATED IN A CONFIDENTIAL MANNER.

SIGNED: \_\_\_\_\_ DATED: \_\_\_\_\_