Utah Basic Napis/Nutrition Intake

Center:	Type/Reason Assessment:	Date:

Last Name:	First:	M.I.

Gender: ☐Male ☐Female	Phone Number:	DOB:

Street Address:	Email:

City:	State:	ZIP:

Current Living Arrangement: ☐ Lives Alone, ☐Spouse/Partner, ☐ Spouse & child ,☐Child/Children ☐ Information Unavailable, ☐ With others, ☐ Not answered

Length at current residence____________________________________

Race
☐ African American
☐ American Indian/Native Alaskan
☐ Asian/Pacific Islander (inc. Hawaiian)
☐ Hispanic Origin
☐ Non-Minority (White Non-Hispanic)
☐ Other
☐ Unavailable

Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

Monthly Income of:	
Individual	**Couple**
$_____________	$_______________

Persons in family/household	
1 ☐	5 ☐
2 ☐	6 ☐
3 ☐	7 ☐
4 ☐	8 ☐

Nutrition Risk Score-Section 1		
	YES	**NO**
1.1 Do you have an illness or condition that made you change the kind and/or amount of food you eat?	☐2	☐0
1.2 Do you eat fewer than two meals per day?	☐3	☐0
1.3 Do you eat fewer than five (5) servings (1/2 cup each) of fruits or vegetables every day?	☐1	☐0
1.4 Do you eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day?	☐1	☐0
1.5 Do you have enough money to buy food?	☐0	☐4
1.6 Do you have trouble eating due to problems with chewing/swallowing?	☐2	☐0
1.7 Do you eat alone most of the time?	☐1	☐0
1.8 Without wanting to, have you lost or gained 10 pounds in the past 6 months?	☐2	☐0
1.9 Are you physically unable to shop, cook and/or feed yourself (or to get someone to do it for you)?	☐2	☐0
1.10 Do you have 3 or more drinks of beer, liquor or wine almost every day?	☐2	☐0
1.11 Do you take 3 or more prescribed or over-the-counter drugs per day?	☐1	☐0
TOTAL Nutrition Risk Score		

Check your Nutritional Score here. If it's:
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. Your office on aging, senior nutrition program, senior citizens center or health department can help. Recheck your nutritional score in 3 months.
6 or More 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.

Utah Nutrition Status Sheet-Section 2			
	Good	Fair	Poor
2.1 At the present time please rate your emotional health	☐0	☐1	☐2
2.2 At the present time please rate your physical health	☐0	☐1	☐2
2.3 Has your nutrition suffered due to unforeseen health care costs?	☐ 1	☐ 0	☐ 0

2.4 Not including the Home Delivered Meal or Senior Center Meal where do you get your meals:
Cook for yourself ☐ 0   Family or friends ☐ 0   Easy meals with the microwave ☐ 0
Eat at restaurants ☐ 1   Save food from other meals ☐ 1   Foodbank – Senior Meal Boxes ☐ 1
Eat less ☐ 2   Skip meals ☐ 2   Pre-packaged food (e.g. high sodium, high fat) ☐ 2

2.5 Without the Home Delivered Meal or Senior Center Meal would you eat?
About the same amount of food ☐ 0   More food ☐ 0   Less food ☐1

2.6 As a result of Home Delivered Meal or Senior Center Meal Program	Yes	N/A	No
a. I am able to eat a healthier variety of food	☐ 0	☐ 0	☐ 1
b. I am able to follow the special diet that is prescribed by my doctor or dietitian	☐ 0	☐ 0	☐ 1
c. I eat less salt	☐ 0	☐ 0	☐ 1
d. I eat less high fat foods	☐ 0	☐ 0	☐ 1
e. I can achieve or maintain a healthy weight	☐ 0	☐ 0	☐ 1
f. I feel better	☐ 0	☐ 0	☐ 1
g. I feel less hungry throughout the day	☐ 0	☐ 0	☐ 1
h. I can continue to live in my own home	☐ 0	☐ 0	☐ 1
i. At the present time I know what to eat for my health condition/s	☐ 0	☐ 0	☐ 1
2.7 Do you have the resources to continue living in your home because of this meal program	Yes: ☐ 0	NA: ☐ 0	No: ☐1
2.8 At the present time how many days each week do you receive home delivered or congregate meals?	0-2: ☐1	3 +: ☐0	
Total Risk Score Section 2			

Activity Levels (IADL's)				
4.1 During the past 7 days How would you rate your ability to perform the following	Self Sufficient	Supervised	Requires Assistance	Must Have Help
	☐0	☐1	☐2	☐3
4.2 Manage medications?	☐0	☐1	☐2	☐3
4.3 Manage money?	☐0	☐1	☐2	☐3
4.4 Heavy housework?	☐0	☐1	☐2	☐3
4.5 Light housekeeping?	☐0	☐1	☐2	☐3
4.6 Shopping?	☐0	☐1	☐2	☐3
4.7 Transportation?	☐0	☐1	☐2	☐3
4.8 Use the telephone?	☐0	☐1	☐2	☐3
Subtotal:				
TOTAL IADL SCORE				

Emergency Contact Name/Relationship	Emergency Contact Phone
Emergency Contact Name/Relationship	Emergency Contact Phone
Any other Information you want us to know?:	