Nutritional Assessment

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home delivered meal OR Senior congregate meal site (circle one)

**Does the client have a specific diet?**

1. Yes, Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. No

**Does the client have a food allergy?**

1. Yes, Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. No

**Nutritional Screening** (Select all that apply.)

Do you have an illness or condition that has changed the way you eat?

Do you eat fewer than 2 meals per day?

Do you eat less than 2-3 servings of fruits, vegetables, and dairy per day?

Do you have 3 or more drinks of beer, liquor, or wine almost every day?

Do you have tooth or mouth or gum problems that make it hard for you to eat or swallow?

Do you sometimes run out of money to buy food?

Do you eat alone most of the time?

Have you lost of gained 10 pounds in the last 6 months without trying?

Is it difficult for you to shop, cook, of feed yourself at times?

Do you eat or drink milk products? (less than 2 servings total, ie. 1 cup of milk or yogurt is a serving)

Do you drink less than 4 glasses of water daily?

Do you drink 2 or more cups of caffeinated coffee/tea daily?

Do you drink a liquid supplement?

Comments: