

_____ Birth Date _____
 Last Name (Please Print) First Name

Street Address City Zip Township

Home Phone: _____ Cell Phone: _____

Please Check: Male Female Veteran Email: _____

Mobility Aid (circle if used): Wheelchair Standard Walker Walker with Seat Oxygen

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

How did you hear about us: From a friend Hanover Happenings Club 59 Social Service Need

Transportation Social Media Website Community Organization Newspaper Other _____

Ethnicity: Check One

Hispanic Non-Hispanic

Race: Check All that Apply

White

Black or African American

American Indian or Alaska Native

Asian

Native Hawaiian or Other Pacific Islander

Other Race

Please Circle Yes or No

Do you live alone? Yes No

- If "yes", does your monthly income exceed \$1,015?

Yes No

- If "no", does your monthly household income exceed \$1,360?

Yes No

Are you limited in understanding and speaking English?

Yes No

If "Yes" what is your primary language: _____

PLEASE COMPLETE BOTH SIDES AND SIGN



PLEASE COMPLETE BOTH SIDES**Please Circle Yes or No**

1. Have you made any changes in lifelong eating habits because of health problems? **Yes** **No**
2. Do you eat less than 2 meals per day? **Yes** **No**
3. Do you eat fewer than five servings (1/2 cup each) of fruits or vegetables every day? **Yes** **No**
4. Do you eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day? **Yes** **No**
5. Have there been times when you did not have enough money to buy food? **Yes** **No**
6. Do you have trouble eating well due to problems with chewing/swallowing? **Yes** **No**
7. Do you eat alone most of the time? **Yes** **No**
8. Without wanting to, have you lost or gained 10 pounds in the last 6 months? **Yes** **No**
9. Have there been times when you were unable to shop, cook or feed yourself? **Yes** **No**
10. Do you have 3 or more drinks of beer, liquor or wine almost every day? **Yes** **No**
11. Do you take 3 or more different prescribed or over-the-counter drugs per day? **Yes** **No**

Signature**Date**