Circle: New - Change - Delete Registrant Number_____ "Q" Entry Date_____ Initial___

Please check one for clients under 60:
___ Volunteer
___ Spouse of a senior
___ Disabled caregiver
___ Disabled accompanying senior
___ Disabled living at senior house (Stevenson House, John 23rd and Mabuhay Apartments)

Santa Clara County Senior Nutrition Program

1367 Registration - Site Name: _____

PLEASE PRINT CLEARLY

Participant Information - complete all fields			
First Name:	**MI**	**Last Name**	**Date**

Street Address	**City**	**State**	**Zipcode**	**Phone Number**
				( ) ___ ___ ___ ___ ___ ___ ___

Birthdate: Month	**Day**	**Year**

Sex: (check below)

Male ____ Female ____

Marital Status: (circle below)

Single Married Divorced Widowed

Ethnicity (circle one)

African American **American Indian/Alaskan Native**
Hispanic **Caucasian** **Portuguese** **Other**_____
Asian/Pacific Islander: Asian Indian Cambodian Chinese
Filipino Guamanian Hawaiian Japanese Korean Laotian
Other Asian/Pacific_____ Samoan Vietnamese

Social Security Number - List below	**Primary Language - List below**
-- --	

Do You Receive SSI or SSP?	**Yes** ____	**No** ____
Are You a Low Income Household?	**Yes** ____	**No** ____
Do You Live Alone?	**Yes** ____	**No** ____

Nutrition Risk Assessment

Must be completed for the following programs:
Congregate Nutrition/Meals on Wheels

Check all that apply:	**YES**
I have an illness or medical condition that changes the kind and/or amount of food I eat	
I eat less than 2 meals per day	
I eat less than 2 daily servings of each of these food groups: fruits, vegetables, milk products	
I have three or more drinks of beer, liquor, or wine almost every day	
I have tooth or mouth problems that make it hard to eat	
I do not always have enough money to buy the food I need	
I eat alone most of the time	
I take three or more prescribed or over the counter drugs a day	
Without wanting to, I have lost or gained 10 pounds in the past six months	
I am not always physically able to shop, cook and/or feed myself	

If none of the above statements apply, initial here: _____

Emergency Contact Information

Name:	**Relationship:**
Address:	**State/Zip**
Phone #1:	**Phone #2**
Doctor:	**Phone:**