

**NAPIS NUTRITION REGISTRATION FORM**  
**Westchester County Department of Senior Programs & Services**

**Today's Date:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

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

**Address:** \_\_\_\_\_ **Town** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Male:** \_\_\_\_ **Female:** \_\_\_\_ **Live Alone:** Yes \_\_\_\_ No \_\_\_\_ **Number in Household** \_\_\_\_

**Marital Status:** Married \_\_\_\_ Widowed \_\_\_\_ Single/Never Married \_\_\_\_ Divorced \_\_\_\_

**Race:** White \_\_\_\_ Black \_\_\_\_ American Indian \_\_\_\_ Hispanic/Latino \_\_\_\_ Asian \_\_\_\_  
Hawaiian/Pacific Is. \_\_\_\_ Other \_\_\_\_

**Ethnicity:** Hispanic \_\_\_\_ Non-Hispanic \_\_\_\_

**Monthly Income:**

Family Size = 1:	Less than: \$866 ____	Less than: \$1,300 ____	More than: \$1,300 ____
Family Size = 2:	Less than: \$1,167 ____	Less than: \$1,750 ____	More than: \$1,750 ____
Family Size = 3:	Less than: \$1,467 ____	Less than: \$2,650 ____	More than: \$2,650 ____

**Frail/Disabled:** Yes \_\_\_\_ No \_\_\_\_ **Veteran:** Yes \_\_\_\_ No \_\_\_\_

**Medical or Emergency Contact Information:**

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

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

**Home Phone:** \_\_\_\_\_ **Business/Cell Phone:** \_\_\_\_\_

**Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Medical Conditions:** \_\_\_\_\_ **Medications?** Yes \_\_\_\_ No \_\_\_\_

If so, please list: \_\_\_\_\_

**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, please specify: \_\_\_\_\_

**Are you allergic to any medication?** No \_\_\_\_ Yes \_\_\_\_ If yes, please specify: \_\_\_\_\_

**Do you require assistance with grocery shopping?** Yes \_\_\_\_ No \_\_\_\_

**(Turn Page Over To Complete) → →**

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

**How do you expect to get to this site:** Walk: \_\_\_\_\_ Drive your own car: \_\_\_\_\_ Ride with a friend: \_\_\_\_\_  
Public Transportation: \_\_\_\_\_ Nutrition Site Transportation: \_\_\_\_\_

**Services:**

- |   |  |
|---|--|
| _____ Sundays Alive (III-C1)              | _____ Sundays Alive Transportation (IIIB)    |
| _____ Senior Center at Lake Isle (III-C1) | _____ Nutrition Center Transportation (IIIB) |
| _____ Garth Road Center Meals (III-C1)    | _____ Nutrition Education (III-C1)           |

**Please answer the following Nutrition Questions:**

**If yes, circle number:**

- |  |                                      |          |
|--|--------------------------------------|----------|
| Do you eat fewer than 2 meals per day:                                     | No ___ Yes ___                       | <b>3</b> |
| Do you have a condition that changes the kind and/or amount of food eaten: | No ___ Yes ___                       | <b>2</b> |
| Do you eat fewer than 2 ½ cups of fruits or vegetables daily:              | No ___ Yes ___                       | <b>1</b> |
| Do you eat fewer than 2 servings of dairy products daily:                  | No ___ Yes ___                       | <b>1</b> |
| Do you have 3 or more drinks of beer, liquor or wine daily:                | No ___ Yes ___                       | <b>2</b> |
| Do you eat alone most of the time:   | No ___ Yes ___                       | <b>1</b> |
| Do you have trouble eating due to problems swallowing/chewing:             | No ___ Yes ___                       | <b>2</b> |
| Do you sometimes have problems buying food because of income:              | No ___ Yes ___                       | <b>4</b> |
| Do you take 3 or more prescribed or over the-counter drugs a day:          | No ___ Yes ___                       | <b>1</b> |
| Without wanting to, lost or gained 10 pounds in the past six months:       | No ___ Yes, gained ___ Yes, lost ___ | <b>2</b> |
| Are you not always physically able to shop, cook and/or feed self:         | No ___ Yes ___                       | <b>2</b> |

(Add scores of **Yes** answers)      **TOTAL** \_\_\_\_\_

**Nutritional Health Score:**

- 0 – 2    Good Nutritional Health:
- 3 – 5    Moderate Nutritional Risk
- 6 +     High Nutritional Risk

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: \_\_\_\_\_ DATE: \_\_\_\_\_