

**INTAKE INFORMATION**

A. Person's Name: \_\_\_\_\_

B. Address: \_\_\_\_\_

C. Phone # \_\_\_\_\_ DOB/Age \_\_\_\_\_

D. Date of Referral: \_\_\_\_/\_\_\_\_/\_\_\_\_  
VETERAN? YES NO  
FRAIL/DISABLED? YES NO  
LIVES ALONE? YES NO  
ETHNICITY \_\_\_\_\_

E. Referral Source (specify Name, Agency, Phone): \_\_\_\_\_  
\_\_\_\_\_

F. Presenting Problem/Person's Concern(s): \_\_\_\_\_  
\_\_\_\_\_

G. Has this person ever received meals from us? YES NO If YES, when? \_\_\_\_\_

H. Does the person know that a referral has been made? YES NO If not, why?  
\_\_\_\_\_  
How long do you anticipate the meals will be needed? \_\_\_\_\_

I. Emergency Contact:  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

J. Doctor's Name: \_\_\_\_\_

K. Dietary Restrictions:  
None Diabetic Low Salt Other: \_\_\_\_\_

L. Has a physician prescribed this special diet? YES NO

M. Meal Plan: M-F weekend – frozen \_\_\_\_\_

N. Start Date: \_\_\_\_\_

O. Assessment Date: \_\_\_\_\_

P. Six month contact due date: \_\_\_\_\_

Directions to house: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Intake Worker's Name \_\_\_\_\_ Animals \_\_\_\_\_

The client information contained in this assessment instrument is Confidential and may be shared with others only as necessary to implement the client's care plan and comply with program requirements, including but not limited to monitoring, research and evaluation.