NORTHEAST IOWA
Area Agency on Aging

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|---|---|---|
| **Today's Date:** / / | **Preferred Phone:** ( ) | |
| **First Name:** | **Last Name:** | **MI:** |
| **Date of Birth:** / / | **Email:** | |
| **Address:** | **City:** **State:** | **Zip:** |

The following data is asked by our funders and will not be disclosed by name.

**Gender:** ☐ Female ☐ Male ☐ Other

**Primary Language:** ☐ English ☐ Other:

**Check the racial categories that apply to you:**

☐ White ☐ Asian ☐ African American/Black ☐ American Indian/Alaskan Native

☐ Native Hawaiian/Other Pacific Islander

**Are you Hispanic or Latino?** ☐ Yes ☐ No

**Are you a veteran?** ☐ Yes ☐ No

**Do you live alone?** ☐ Yes ☐ No

If Yes, is your annual household income more than $12,760? ☐ Yes ☐ No

**If No, is your annual household income more than:**

If 2 people, is your annual household income more than $17,240? ☐ Yes ☐ No

If 3 people, is your annual household income more than $21,720? ☐ Yes ☐ No

If 4 people, is your annual household income more than $26,200? ☐ Yes ☐ No

If 5 people, is your annual household income more than $30,680? ☐ Yes ☐ No

If 6 or more people, is your annual household income more than $35,160? ☐ Yes ☐ No

**Are you interested in learning about any other services?**

☐ Nutrition & Meals ☐ Transportation ☐ Legal Assistance ☐ Caregiver Support

☐ Health and Fitness Classes ☐ Options to stay at home ☐ Options to return to home

| Measure your Nutrition Risk! | |
|---|---|
| 1. Have there been any changes in your eating habits because of health problems? | ☐ Yes ☐ No |
| 2. Do you eat less than 2 meals a day? | ☐ Yes ☐ No |
| 3. Do you eat few fruits, vegetables, or milk products? | ☐ Yes ☐ No |
| 4. Do you have 3 or more drinks of beer, wine, or liquor almost every day? | ☐ Yes ☐ No |
| 5. Do you have a tooth or mouth problem that makes it hard to eat? | ☐ Yes ☐ No |
| 6. Do you always have enough money to buy the food you need? | ☐ Yes ☐ No |
| 7. Do you eat alone most of the time? | ☐ Yes ☐ No |
| 8. Do you take 3 or more different prescribed or over-the-counter | ☐ Yes ☐ No |
| 9. Have you had unexpected weight gain or loss of 10+ pounds in the past 6 months? | ☐ Yes ☐ No |
| 10. Are there times your physically unable to shop, cook, or feed yourself? | ☐ Yes ☐ No |
| 11. In the past 30 days, have you worried about whether your food would run out before you got money to buy more? | ☐ Yes ☐ No |
| 12. In the past 30 days, did the food you buy just not last and you didn't have | ☐ Yes ☐ No |
| 13. Do you feel lonely sometimes or often? | ☐ Yes ☐ No |