COMMUNITY SERVICES
Senior Services

NUTRITION RISK ASSESSMENT

CLIENT'S NAME

NUTRITIONAL RISK ☐ DECLINED TO STATE			POINTS
1. I have an illness or condition that made me change the kind and/or amount of food I eat.	☐ YES	☐ NO	2
2. I eat fewer than 2 meals per day.	☐ YES	☐ NO	3
3. I eat few fruits or vegetables, or milk products	☐ YES	☐ NO	2
4. I have 3 or more drinks of beer, liquor or wine almost every day.	☐ YES	☐ NO	2
5. I have tooth or mouth problems that make it hard for me to eat.	☐ YES	☐ NO	2
6. I do not always have enough money to buy the food I need.	☐ YES	☐ NO	4
7. I eat alone most of the time.	☐ YES	☐ NO	1
8. I take 3 or more different prescribed or over-the-counter drugs a day.	☐ YES	☐ NO	1
9. Without wanting to, I have lost or gained 10 pounds in the last 6 months.	☐ YES	☐ NO	2
10. I am not always physically able to shop, cook and/or feed myself.	☐ YES	☐ NO	2
11. Do you have less than 5 cups (8 oz. per cup) of fluids per day?*	☐ YES	☐ NO	

*Question is not part of the Nutrition Risk scoring.

TOTAL

HIGH NUTRITIONAL RISK? *(High nutritional risk is a score of 6 or more points)* ☐ YES ☐ NO

REFRIGERATOR: TEMPERATURE ______________ DATE ______________

FOR C-2 CLIENTS		
1. Does the client have any dietary restrictions?	☐ YES	☐ NO
2. Does the client have a working refrigerator?	☐ YES	☐ NO
3. Does the client have a working microwave?	☐ YES	☐ NO
4. Is the client physically/mentally able to open the food containers?	☐ YES	☐ NO
5. Is the client physically/mentally able to reheat a meal?	☐ YES	☐ NO

FOR OFFICE USE ONLY

ID# ______ CLIENT ASSESSMENT DATE ______ ☐ HV ☐ PC COMPLETED BY ______