Community Servings

Client Intake Form

Client Information

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Date of Birth: ____/____/_____ **Gender (please circle one): Male Female Transgender**

Address: _____ **Apt #**_____

City: _____ **State:** _____ **Zip Code:** _____

Primary Phone: _____ **Alternate Contact (Name and Number):**

Other Phone: _____ _____

Email: _____ _____

Demographics

Primary Language: □English □Spanish □Other (please specify) _____

Race: □ African □ African American/ Black □ Asian □ American Indian/Alaskan Native □ Native Hawaiian/Pacific Islander □ White Caucasian □ Other (please specify)_____

Hispanic or Latino/a: □Hispanic or Latino/a □ Not Hispanic or Latino/a □Unknown/Unreported

Country of Birth: □ USA □ US Dependencies, including Puerto Rico □ Other_____

Housing and Income Information

Housing (you must choose one): □ Permanent Housing □ Supportive Housing □ Institution □ Other (please specify) _____ □ Unknown/ Unreported

I have access to: □ Refrigerator □ Stove □ Microwave □ Oven □ Freezer □ None □ Other:_____

Do you have someone to help you? □ Visiting Nurse □ Home Health Aide □ Family Member/Friend □ No Help □ Other (please specify) _____

Income Source_____

Monthly Income_____

For applicants with HIV/AIDS– You must submit a recent copy (within the last 6 months) of your Income Verification (examples include: SSI statement, four pay stubs, bank statement, or letter stating no income on letterhead from your service provider). Updated income verification is required every 6 months.

Insurance Information

Health Insurance: □ MassHealth Medicaid □ MassHealth Medicare □ Private Insurance (specify) _____ □ Public Insurance □ No Insurance □ Other (specify) _____

□ Are you a CCA (Commonwealth Care Alliance) One Care or SCO member? If so please call **617-522-7777** to speak to Client Services.

Personal Identification

Mother's First Name: _____

Last four digits of Client's Social Security Number: ____ ____ ____ ____

Emergency Contact Information

Community Servings - 18 Marbury Terrace- Jamaica Plain, MA 02130- Tel. 617-522-7777 - Fax **617-522-7770** Revised: February 2014

Emergency Contact Name: _____ **Relationship:** _____

Address: _____

Primary Phone: _____ **Other Phone:** _____
Is the emergency contact aware of client's status or illness? _____

Referral Information

Referral Source: □ Self □ Case Management □ Substance Abuse Program □ Homeless Service
□ Health Center □ Doctor, Nurse or Dietitian □ Dialysis □ Hospice □ Other: _____

Referral Name: _____ **Title:** _____

Referral Agency: _____

Phone: _____ **Email Address:** _____

Support Systems *(if different from referral source)*

Name of Primary Care Physician: _____**Phone:** _____

Agency/ Clinic: _____ **FAX:** _____

Name of Social Worker/ Case Manager: _____ **Phone:** _____

Agency: _____ **Email:** _____

Medical Information

If AIDS or HIV+, please indicate exposure category (check those that apply): □ MSM □ WSW □ Injection drug use □ Heterosexual Contact □ Perinatal Transmission □ Hemophilia □ Through blood, blood products, tissue □ Other risk □ Unknown

Mental Health
Are you experiencing? : □ Angry Outbursts □ Anxiety □ Poor Memory □ Insomnia □ Nervousness □ Poor appetite □ Depression

Have you been treated or are you currently being treated for: □ Schizophrenia □ Bipolar □ Depression □ Drug/Alcohol Addiction (In recovery for how long?_____) □ Other: _____

Previous Hospitalizations:

Date	Reason	Medical Center

Medical Follow ups: □ Regular Check-ups □ Goes to the ER □ Only when ill □ Never □ Unknown
□ Other: _____
□ Standing appointments (What days?):_____

Nutrition & Diet Information

Community Servings - 18 Marbury Terrace- Jamaica Plain, MA 02130- Tel. 617-522-7777 - Fax **617-522-7770** Revised: February 2014

Current Weight: _____ Height: _____

Questions	YES	NO
Do you have any food allergies? If yes, please list **each allergy** and the **type of reaction** you have below:		
Have you **unintentionally** lost weight in the past 6 months? If yes, how much?		
Have you **unintentionally** gained weight in the past 6 months? If yes, how much?		
Has your appetite changed in the last 6 months? If yes, describe:		
Do you have any problems chewing? If yes, describe:		
Do you have any problems swallowing? If yes, describe:		
Do you have nausea or vomiting? If yes, how often and for how long?		
Do you have diarrhea? If yes, how often and for how long?		
Do you drink Boost or Ensure?		

Please write any other nutrition or food concerns here: _____

_____

_____

Our nutrition staff may contact you to review your responses with you.

Type of Diet: Please choose up to three (3) diet restrictions

- ❑ Regular
- ❑ Diabetic
- ❑ Low Fat / Low Cholesterol
- ❑ No Citrus, no Tomatoes
- ❑ Low Fiber
- ❑ Low Vitamin K
- ❑ Renal
- ❑ Bland – low in sodium and mild
- ❑ Soft
- ❑ No Nuts
- ❑ No Red Meat
- ❑ No Dairy – no butter, milk or cheese
- ❑ No Eggs
- ❑ No Fish/Shellfish
- ❑ No Poultry
- ❑ Vegetarian – no meat, chicken or fish/ shellfish
- ❑ Children's Menu

Milk: □ Skim/nonfat □ 1% □ 2% □ Lactaid

Please Note: We are not a food allergen-free facility. Meals may contain traces of nuts, fish, shellfish, dairy, and/ or eggs. We are unable to accommodate gluten-free restrictions, wheat and soy intolerances or any other restrictions not listed above. We do not use pork products in any of our meals.

Persons in Household

Community Servings, in addition to the primary client, will provide meals to a caregiver or parent/spouse and any children under the age of 18 years.

Relationship	Diet selection (see above)	Race	Gender	Date of Birth

Delivery Instructions

Please provide any relevant delivery information (e.g., gates, buzzers, codes, or standing appointments such as dialysis): _____

_____

_____

Person completing the intake: _____

Client's signature: _____ **Date:** _____

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