Hot & Frozen Meal Program
Client Intake Form

Date (M/D/Y): ______________________ **Completed By:** ______________________

Section 1: CLIENT INFORMATION

Full Name (First, Last) :		**Gender:** Female Male Non-binary
Phone #:		
Email:		
Date of Birth (M/D/Y):		
Address:		
City:	**Postal Code:**	
Are you a Veteran?	**Do you live alone?**	**Have pets?**

Section 2: CONTACTS

EMERGENCY CONTACTS	
1.	**Name:** **Phone #:** **Address:** **Relationship:**
2.	**Name:** **Phone #:** **Address:** **Relationship:**

FORMAL CONTACTS (if required)	
Other Support Services used?	

Section 3: ASSESSMENT

Health Status Considerations	
Food allergies: Dietary preferences: Diabetic High blood pressure	*Comments:*

Special Consideration/Devices Used		
Vision	☐ No concern Glasses ☐ Visually impaired ☐ Legally blind	*Comments:*
Eating	No concern Some difficulty chewing Some difficulty swallowing Food aversion Other:	*Comments:*
Hearing	No concern Hearing aid Hearing impaired Legally deaf	*Comments:*
Mobility	☐ Independent ☐ Cane/Walker ☐ Wheelchair/Scooter	*Comments:*

Section 4: PROGRAM SELECTION

Check all that apply	Program	Description				
	Meals On Wheels - Frozen meals	Order weekly frozen meals from our menu that can be picked up or delivered to your home (on Wednesdays)				
	Meals On Wheels - Hot meals	Order daily hot meals from our menu that will be delivered to your home (Monday - Friday)				
Days	I would like to receive hot meals on:	M	T	W	Th	F

Delivery **Pick Up** **Delivery instructions:**

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Section 5: BILLING

Send to client: Mail Email

Send to third party:

Contact name: ______________________

Address: ___________________________

Phone number: ______________________

Email: _____________________________