COMMUNITY PARTNERSHIP ON AGING

ACCESS Registration Form

Today's Date: _____ ____ ID/DL

Last Name: _____ First: _____ MI:____ Mr. / Ms. / Mrs.

Gender: _____ Date of Birth: _____ Last four digits of Social Security#: _____

Marital Status: _____ Phone: _____ Alt. Phone_____

Email: _____ Address: _____

City: _____ Zip:_____ County _____

US Citizen _____ Ohio Resident_____ Est. Monthly Income _____

Number of People in Household _____ Housing Status_____ Type of Housing:_____

Employment Status_____ Veteran Status: _____

Oxygen Dependent_____ Dialysis _____ Disability_____

Emergency Contact: _____

Phone (home): _____ Cell: _____

Relationship: _____

Registrant's primary language:

__ English __ Portuguese ___Spanish

__ Korean __ French __Vietnamese

__German __ Russian __ Italian

___Japanese __ Mandarin

__ American Sign Language

Other_____

Registrant's Race:

__American Indian/Native Alaskan __ Asian

__Black or African American __White

__Native Hawaiian or Other Pacific Islander

__Other _____

Registrant's Ethnicity:

___ Hispanic or Latino ___Not Hispanic or Latino

___ Unknown

UCLA Loneliness Scale

1) How often do you feel that you lack companionship?

Hardly Ever Some of the Time Often

2) How often do you feel left out?

Hardly Ever Some of the Time Often

3) How often do you feel isolated from others?

Activity Level

___ Active

___ Have been active in the past

___ Want to be active

___ Want to find friendship and be with others

___ Have experienced a recent loss

___ Almost never leave home

___ Physical (functional) limitations?

_____

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Activity Range

Limited Range of Motion: ___Hands ___ Arms/Shoulders ___Hips ___ Knees/Legs ___Stairs ___Walking

Devices Used: ___Oxygen ___ Cane __Walker ___Wheelchair Comments/Other _____

Other accommodations needed (Dietary, Hearing, Vision, etc.) _____

Nutritional Risk

Yes/ No- **1)** Have you made any changes in lifelong eating habits because of health problems?

Yes/ No- **2)** Does the client eat fewer than two meals a day?

Yes/ No- **3)** Do you eat fewer than five (5) servings (1/2 cup each) of fruits or vegetables a day?

Yes/ No- **4)** Do you eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day?

Yes/ No- **5)** Do you sometimes not have enough money to buy food?

Yes/ No- **6)** Do you have trouble eating well due to problems with chewing/swallowing?

Yes/ No- **7)** Do you eat alone most of the time?

Yes/ No- **8)** Without wanting to, have you lost or gained 10 pounds in the past 6 months?

Yes/ No- **9)** Are you not always physically able to shop, cook and/or feed themselves (or to get someone to do it for you)?

Yes/ No- **10)** Do you have 3 or more drinks of beer, liquor or wine almost every day?

Yes/ No- **11)** Do you take 3 or more different prescribed or over-the-counter medications per day?

SCORE_____

Interests (Please circle interests)

Exercise Arts & Crafts Music Educational Social Cooking Internet/Technology Travel Games/Puzzles

Other/Comments:

My signature below acknowledges the following policies have been explained and a copy has been made available to me. 1) Disclosure and Privacy Practices, 2) Statement of Client Rights and Responsibilities, 3) Agency Code of Ethics, 4) Grievance and Suggestion Policy and 5) Conduct Policy.

CLIENT Signature: _____ DATE: _____

STAFF Signature: _____ DATE: _____

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