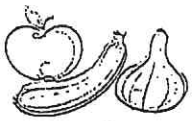

NUTRITIONAL SURVEY

** Read the statements below. Check the appropriate answer.*	Yes	No	Score
1. Do you eat *less* than two (2) meals a day?			3
2. Do you eat alone most of the time?			1
3. Do you consume *less* than two (2) servings of milk or milk products in your daily diet? If yes, why? _____			1
4. Do you eat *less* than five (5) servings of fruits and/or vegetables each day?			1
5. Do you have three (3) or more drinks of beer, liquor or wine every day?			3
6. Have you gained 10 pounds or more in the last six months without wanting to?			2
7. Have you lost 10 pounds or more in the last six months without trying to?			2
8. Do you have a health problem or illness that makes you change the kind and/or amount of food you eat? If yes, please specify: _____			2
9. Do you take three (3) or more different prescribed or over-the-counter drugs in a day?			1
10. Do you need assistance, most of the time, with these daily activities? Please check: _____ food shopping _____ meal preparation _____ eating			2
11. Do you have tooth or mouth problems that make it hard for you to eat?			2
12. Do you sometimes run out of money to buy food that you need?			4
_____Age _____Male _____Female _____Height _____Current Weight **Survey Total**			

** After completing the survey, would you like to discuss this with someone?* _____*YES* _____*NO*

_____*Score* _____*Good* _____*Moderate* _____*High*

Name_____ **Date**_____ **Phone No.**_____