Meals On Wheels

A Myriad of Services For The Senior Adult

Client Information

First Name:_____
Middle Initial:_____
Last Name:_____
Physical Address:_____
Mailing Address:_____
City:_____
State:_____
Zip:_____
Inside or Outside City Limits:_____
County:_____
Phone:_____
Phone 2:_____
Client's Primary Language:_____
Gender:_____
Birth Date:_____
Client Physician:_____
Physician Phone:_____
Race:_____
Marital Status:_____
Does Client live alone?_____
Total number in household including client:_____
Approximate Monthly Income:_____
Does the Client have a Caregiver:_____
Caregiver Contact Information:_____
_____

Person entering data contact Information:

_____
_____
_____
_____
_____

PLEASE LIST ALL MEDICATIONS BY NAME

_____
_____
_____
_____
_____
_____

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MEDICAL NOTES
CHECK ALL THAT APPLY

- ☐ **DIABETES**
- ☐ **INSULIN DEPENDANT**
- ☐ **HYPERTENSION**
- ☐ **HIGH BLOOD PRESSURE**
- ☐ **ARTHRITIS**
- ☐ **OSTEOPOROSIS**
- ☐ **MALNUTRITION**
- ☐ **PARKINSONS**
- ☐ **CANCER**
- ☐ **KIDNEY DISORDER**
- ☐ **DIALYSIS**
- ☐ **STROKE**
- ☐ **PARALYSIS**
- ☐ **DEAF**
- ☐ **DEMENTIA**
- ☐ **ALZHEIMERS**
- ☐ **BLIND**
- ☐ **EYE DISEASES - PLEASE LIST**
- ☐ **PULMONARY DISORDER**
- ☐ **HEART CONDITION**
- ☐ **MENTAL HEALTH IMPAIRMENT**

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Please list all other medical issues

_____

_____

_____

_____

_____

_____

NOTES

***Please note that a member of our case management personnel will contact you to complete your assessment and discuss Meals on Wheels programs with you.**

SEND FORM TO:

Meals On Wheels Ministry Inc.
P.O. Box 5475
Tyler, TX 75712

Fax: 903-595-6350