2026 CLIENT REGISTRATION FORM

Agency/Center _____ **Date**_____

Last Name **First Name** **Date of Birth** (Month / Day / Year) **Address**	**Race/Ethnicity** *(select one or more; information collected for federal statistics)* ☐ Asian ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Hispanic or Latino/a ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Prefer not to say
Telephone Number Home: Mobile:	**Gender** ☐ Female ☐ Male ☐ Transgender ☐ Non-binary ☐ Questioning/Not Sure ☐ Not Listed ☐ Prefer not to say
Email Address: **Veteran or Veteran Dependent :** ☐ Veteran ☐ Veteran Dependent ☐ Neither	**Sexual Orientation** (optional): ☐ Heterosexual/Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Questioning/Not Sure ☐ Prefer not to say

Income (select one)	**One Person**	**Two Persons**
At or Below Poverty:	☐ $0 - $1,330 per month	☐ $0 - $1,803 per month
Above Poverty:	☐ $1,331 per month or above	☐ $1,804 per month or above

Check YES or NO:	**YES**	**NO**
Lives alone		
Disabled - Having a physical or mental disability that restricts the ability of an individual to perform normal daily tasks or threatens the capacity of the individual to live independently.		

Emergency Contact(s):

Name:_____ Name:_____

Relationship to Client: _____ Relationship to Client: _____

Telephone #: _____ Telephone #: _____

Updated 2/10/2026

Bergen County Nutrition Programs
Client Nutrition Screen

Client: _____ Date: _____

DETERMINE YOUR NUTRITIONAL HEALTH	Yes	No
1. Do you eat fewer than 2 meals per day?	3	0
2. Do you eat alone most of the time?	1	0
3. Do you eat fewer than 2 servings of milk or milk products every day?	1	0
4. Do you eat fewer than 5 servings of fruit and/or vegetables every day?	1	0
5. Do you have 3 or more drinks of beer, liquor or wine most days?	2	0
6. Without wanting to, have you lost or gained 10 pounds in the last 6 months? If yes, check one: ☐ lost ☐ gained	2	0
7. Do you have an illness or health condition *(such as diabetes, high blood pressure, high cholesterol)* that made you change the kind and/or amount of food that you eat?	2	0
8. Do you take 3 or more different prescribed or over-the-counter drugs every day?	1	0
9. Are you not always physically able to shop, cook, and/or feed yourself *(or get someone to do it for you)*? Examples: I need help going food shopping, I need help cooking a meal, I need help cutting up food on my plate. **If 'Yes' to ANY OF THESE, circle 'Yes'.**	2	0
10. Do you have problems with your teeth or mouth that make it hard to eat?	2	0
11. Do you sometimes run out of money to buy the food that you need?	4	0
TOTAL		

Total your nutritional score. If it's ...

0 - 2 ***Good!*** Recheck your nutritional score in 6 months.

3 – 5 ***You are at moderate nutritional risk.*** See what can be done to improve your eating habits and lifestyle. Recheck your nutritional score in 3 months.

6 or more ***You are at high nutritional risk.*** You will be referred to the County's Registered Dietitian for Nutrition Counseling.

☐ **Yes, I'd like to discuss this survey with a nutrition professional.** ☐ **No, I'm not interested.**

☐ Male ☐ Female Height _____ Weight _____ (lbs)

Telephone # (_____)_____

The best time to reach me is _____

DETERMINE IF YOU ARE AT RISK FOR MALNUTRITION

1. Have you recently lost weight without trying?	☐ No ☐ Yes	
If yes, how much weight have you lost?	☐ 2 – 13 lbs.	Score 1
	☐ 14 – 23 lbs.	Score 2
	☐ 24 – 33 lbs.	Score 3
	☐ 34 lbs. or more	Score 4
	☐ Unsure	Score 1
		Weight Loss Score: _____
2. Have you been eating poorly because of decreased appetite?	No	Score 0
	Yes	Score 1
		Appetite Score: _____
		TOTAL SCORE: _____

FOOD INSECURITY SCREENING

1. Within the past 12 months, I worried whether my food would run out before I got money to buy more.	☐ Never	☐ Sometimes	☐ Often
2. In the past twelve months, my food didn't last, and I didn't have the money to purchase more.	☐ Never	☐ Sometimes	☐ Often