

MONROE COMMUNITY MENTAL HEALTH NUTRITION SCREEN

NAME: _____

CASE # _____ DATE _____

Circle the number in the box that applies, YES, NO OR N/A. Then total the circled numbers under yes and enter the sum in the Total box.

	YES	NO	N/A
I have an illness or condition that made me change the kind and/or amount of food I eat.	2	0	0
I eat fewer than 2 meals per day.	3	0	0
I eat few fruits or vegetables	1	0	0
I drink milk or eat dairy products once or not at all daily	1	0	0
I have 3 or more drinks of beer, liquor, or wine almost every day.	2	0	0
I have tooth or mouth problems that make it hard for me to eat.	2	0	0
I don't always have enough money to buy the food I need.	4	0	0
I eat alone most of the time.	1	0	0
I take 3 or more different prescribed or over-the-counter drugs a day	1	0	0
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	3	0	0
I am not always physically able to shop, cook and/or feed myself.	2	0	0
I eat breads, cereals, pasta, rice, or other grains five or fewer times daily	1	0	0
I have a poor appetite	1	0	0
I have a food allergy (if Yes describe foods and allergic response)	2	0	0
TOTAL OF ALL CIRCLED NUMBERS			

0.2: GOOD

3-5: MODERATE NUTRITIONAL RISK: See what can be done to improve your eating habits and lifestyle.

6 OR MORE: HIGH NUTRITIONAL RISK See your doctor or other qualified health professional. Ask for help to improve your nutritional health.