ADAPTIVE COOKING

Date: _____ Birthdate: _____

Name: _____ Address : _____

Email: _____ Phone #: _____

Please answer as many of the questions as you can below and check the boxes as necessary.

1. Who cooks for you? (*please select*)

	HOW OFTEN?		
	EVERY DAY	**A FEW TIMES A WEEK**	**RARELY**
YOURSELF	☐	☐	☐
FAMILY MEMBER	☐	☐	☐
PSW	☐	☐	☐
GROUP HOME STAFF	☐	☐	☐
I EAT OUT	☐	☐	☐
2. If you don't cook, do you help?	☐	☐	☐

3. What challenges do you have that make cooking difficult for you?

reaching ☐ hand strength ☐ hearing ☐ vision ☐ comprehension ☐ attention ☐ stamina ☐

Other: _____

4. What appliances and utensils have you used?

Blender ☐ Slow Cooker ☐ Microwave ☐ Toaster Oven ☐ Stove Top ☐ Oven ☐

Electric Chopper ☐ Can Opener ☐ Peeler ☐ Serving Spoon ☐ Knife ☐ Slap Chop ☐

5. If you wish to, identify your disability. (*It will be kept in the strictest confidence*) .

Learning ☐ M.S. ☐ C.P. ☐ H.I. ☐ SCI ☐ S.B. ☐ M.D. ☐ Mental Illness ☐ Arthritis ☐ Seizures ☐

6. If you require volunteer assistance, to what level?_____ Will you provide a volunteer? Yes ☐ No ☐

7. Do you use any of the following mobility devices? (space determination)

Cane ☐ *Walker* ☐ *Scooter* ☐ *Power Wheelchair* ☐ *Manual Wheelchair* ☐ *Service Animal* ☐

8. Please list any food allergies, intolerances or restrictions you have.

_____

9. Is there anything else we should know to help you participate fully in the program? Yes ☐ No ☐

(*if yes please list on reverse side*)