CONFIDENTIAL	**HAWAIʻI CARES INTAKE FORM**	Added to WITS: ☐ YES ☐ NO

Name_____Date:____/____/____Time:____:____AM/PM

To whom are you speaking with (if not client):_____

Do you give consent for Hawaiʻi CARES to contact any agency within our network for an assessment/treatment?

☐YES ☐NO

Do you have any current/immediate medical or psychiatric concerns?

Do you/ Have you lived on a disaster-affected island within the last four years? Note the disaster(s) which affected their island(s).

Current living arrangement:

____Houseless/Homeless____Living in others home_____Living in my own home____Jail/Incarcerated

Address:_____

City/Island:_____Zip Code:_____

Contact number:_____Alternate Phone: _____

# of children living with you_____Age(s):_____Pregnant: ☐ YES ☐ NO

	Name	Relationship	Phone number
Referral Contact			( ) -
Personal Contact			( ) -
Emergency Contact			( ) -

Do you give consent for Hawaiʻi CARES to contact (list collateral contacts) if we are unable to get in contact with you? ☐YES ☐NO

Other Reference No. (A#, Adolescent Judiciary #, etc.): _____

Gender:_____Date of Birth:_____/_____/_____Marital Status: _____

Ethnicity:_____

Race:_____Citizenship:_____Veteran: ☐ YES ☐ NO

Presenting Problem (s) (“In Client‘s Own Words”):

_____

_____

CAGE-AID

1. Have you ever felt you should cut down on your drinking or drug use?	☐ YES	☐ NO
2. Have people annoyed you by criticizing your drinking or drug use?	☐ YES	☐ NO
3. Have you ever felt bad or guilty about your drinking or drug use?	☐ YES	☐ NO
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover (eye opener)?	YES	☐ NO

In the last 30 days have you misused alcohol or other drugs? ☐ YES ☐ NO LDOU:_____

Are you an Injection Drug User? ☐ YES ☐ NO

Do you consume tobacco products? ☐ YES ☐ NO

Have you been in a controlled environment in the past 30 days (e.g. jail)? ☐ YES ☐ NO

If so, where: _____

Do you have a history of causing physical harm to others? ☐ YES ☐ NO

If yes, current risk action: _____

Do you have a history of causing physical harm to yourself? ☐ YES ☐ NO

If yes, current risk action: _____

Describe current legal status:

_____

Current medical problem(s):

_____

List medications currently using (OTC and prescribed):

_____

Health Insurance:_____Membership #:_____

Employment Status: _____

Is transportation a challenge for you? ☐ YES ☐ NO

Have you received treatment in the past? If so, where: _____

What services are you interested in?

☐ Counseling ☐ Sober Living ☐ Outpatient ☐ Residential ☐ Other: _____

REFERRAL

Was the referral made? ☐ YES ☐ NO

If not, please explain:

Notes:

Staff initials: _____