HAWAII CARES INTAKE FORM – CONFIDENTIAL Date: _____ Time: _____

Personal Information

Name: _____ Date of Birth: _____

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

Consent:

Do you give consent for Hawai'i CARES to contact any agency within the our network for an assessment/treatment? YES or NO

Do you have any current/immediate medical or psychiatric concerns? YES or NO

Current Living Arrangements: _____

Address: _____

City/Island: _____Zip code: _____ SSN: _____

Preferred Method of Contact: _____

Mobile Phone: _____ Other Phone: _____

Pregnant: _____ # of children living with you and age(s): _____

Health Insurance: _____ Employment Status: _____

CAGE AID

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

Presenting Problem(s) ("In Client's Own Words"):

Demographic Information

Sex at Birth: _____ Gender Identity: _____ Sexual Orientation: _____

Marital Status: _____Military Dependent: _____

Ethnicity: _____

Race: _____

Religious preference: _____ Citizenship: _____ Veteran Status: _____

Client Contacts:

1. **Referral Contact Name**: _____

   Relationship: _____ Contact number: _____ Consent: YES or NO

2. **Personal Contact Name:** _____

   Relationship: _____ Contact number: _____ Consent: YES or NO

3. **Emergency Contact Name:** _____

   Relationship: _____ Contact number: _____ Consent: YES or NO

In the last 30 days have you misused alcohol or other drugs? _____

Are you an Injection Drug User? _____ Do you consume tobacco products? _____

Have you been in a controlled environment in the past 30 days? (e.g. jail)? _____

If yes, where: _____Other Reference No. (e.g. A#): _____

Describe your current legal status: _____

_____

Do you have a history of causing physical harm to others? _____

If yes, current risk action: _____

Do you have a history of causing harm to yourself? _____

If yes, current risk action: _____

Describe your current medical problems: _____

_____

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

Is transportation a challenge for you? _____

Comments:

Completed by:

Staff Name: _____ Date: _____