HAWAIʻI HEALTH
& HARM REDUCTION CENTER

FOR OFFICE USE ONLY	
MRN:	**E2 ID:**

Please complete the form to the best of your ability.	**Today's Date:**

Reason for Visit:	☐ Testing for HIV/HCV	☐ Psychological probs.	☐ PrEP	☐ STI Testing	☐ Wound Care	☐ Other:
	☐ Case Management	☐ Substance misuse	☐ Transgender Services		☐ Smoking Cessation	

Presenting Problem(s):

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

Last Name:	**First Name:**	**Middle Initial:**
Legal Name: *(if different from above)*	**Pronouns:** *(he/she/they/ze):*	
Social Security Number:	**Date of Birth:** *(MM/DD/YYYY):*	
Sex at Birth: ☐ Female ☐ Male ☐ Other	**Country of Birth:**	**Citizenship:**

Current Gender Identity: ☐ Female ☐ Male ☐ MtF Transgender ☐ FtM Transgender ☐ Other:

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Don't know ☐ Decline to answer

Race: *(check all that apply)*	☐ African American/Black	☐ Chamorro	☐ Marshallese	☐ Pohnpeian	☐ Yapese
	☐ Alaska Native	☐ Chuukese	☐ Native American	☐ Samoan	☐ Decline to Answer
	☐ Asian	☐ Fijian	☐ Native Hawaiian	☐ Tahitian	☐ Don't know
	☐ Caucasian/White	☐ Korean	☐ Palauan	☐ Tongan	☐ Other:

What race do you identify with most?

CONTACT INFORMATION

Mailing Address:	**City:**	**State:**	**Zip:**
Physical Address: *(if different from above)*	**City:**	**State:**	**Zip:**
Phone Number:	**Email:**		

EMERGENCY CONTACT

Last Name:	**First Name:**	**Relationship:**
Phone Number:	**Email:**	

INSURANCE INFORMATION

Do you have health insurance? ☐ Yes ☐ No

Primary Insurance Carrier:	**Subscriber ID:**	**Group ID:**
Member Name:	**Member Date of Birth** *(MM/DD/YYYY):*	
Secondary Insurance Carrier:	**Subscriber ID:**	**Group ID:**
Member Name:	**Member Date of Birth** *(MM/DD/YYYY):*	
Primary Care Provider:	**Clinic Location:**	

REFERRAL INFORMATION

Initial Contact:

Were you referred to us? ☐ Yes ☐ No	**If yes, by whom?**

Do you consent for us to contact the Source of Referral? ☐ Yes ☐ No

Referral Contact Name:	**Phone No.:**
Referral Contact Name:	**Phone No.:**

BACKGROUND INFORMATION				
What is the highest level of education you have completed?	☐ Some school	☐ High school diploma/GED	☐ Some college	☐ Decline to answer
	☐ Associate Degree	☐ Bachelor's degree	☐ Master's degree or higher	
What is your current living arrangement?	☐ Houseless	☐ Living in others' homes	☐ Living in my home	☐ Jail/Incarcerated
What is your household size? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8+			**Are you currently pregnant?** ☐ Yes ☐ No	
No. of Children Living with you: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8+			**Ages:**	
What is your current marital status? ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed				
Are you currently serving in the military? ☐ Yes ☐ No			**Are you a veteran?** ☐ Yes ☐ No	
Are you currently employed? ☐ Yes ☐ No ☐ Retired ☐ Disability ☐ Other:				
Describe your current legal status:				
Do you need transportation assistance? ☐ Yes ☐ No				

ALCOHOL, TOBACCO & SUBSTANCE USE		
Have you been in a controlled environment in the last 30 days? ☐ Yes ☐ No		
☐ Jail ☐ Alcohol/Drug Treatment ☐ Medical Treatment ☐ Psychiatric Treatment ☐ Other:		
Do you use tobacco? ☐ Yes ☐ No	**If yes, amount per day?**	**If yes, are you interested in quitting?** ☐ Yes ☐ No
In the last 30 days, have you misused alcohol or other drugs? ☐ Yes ☐ No		
Have you ever injected hormones, insulin, or other substances? ☐ Yes ☐ No		**Are you an injection drug user?** ☐ Yes ☐ No
What services are you interested in? ☐ Counseling ☐ Sober Living ☐ Outpatient ☐ Residential ☐ Other:		

CAGE-AID
Have you ever felt you should cut down on your drinking or drug use? ☐ Yes ☐ No
Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No
Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No
Have you ever used drugs or alcohol in the morning to steady your nerves or to get rid of a hangover (eye opener)? ☐ Yes ☐ No

MEDICAL INFORMATION		
Current medical problems? ☐ Yes ☐ No	*If yes, please list:*	
Please list medications you are currently using *(both over the counter and prescribed, i.e. diabetes, hypertension):*		
Do you have any current medical or psychiatric concerns? ☐ Yes ☐ No	*If yes, please list:*	
Do you have any chronic health conditions? ☐ Yes ☐ No *If yes, please list:*	**Do you have any mental health conditions?** ☐ Yes ☐ No *If yes, please list:*	
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:*	

ATTESTATION		
Did anyone help you complete this form? ☐ Yes ☐ No	**If yes, name:**	**Relationship:**
I acknowledge that I have received or read the following HHHRC forms (please initial):		

	Consumer Notice of Privacy Practices & Rights (HIPAA)		**HHHRC Grievance Form**
	HHHRC Client Rights & Responsibilities Form		

I have carefully read and completed this form, and have provided current and accurate information to the best of my ability.

Signature	**Print Name**	**Date**