



Ke Ola Mamo
 A Native Hawaiian Health Care System
 1505 Dillingham Blvd, Room 205
 Honolulu HI 96817

Account #: _____
Keiki Intake Packet

Client Information			
Client Name:			Date:
Last	First	M.I.	
Mailing Address:		City:	Zip Code:
Street Address:		City:	Zip Code:
Home Phone #:		Work/Cell Phone #:	
Emergency Contact Person: (If possible someone outside your home we may talk to about your health)		Relationship:	Emergency Contact #:
Who may we talk to about your health?		Relationship:	Phone #:
Can we say, "Ke Ola Mamo" when we write or call? <input type="checkbox"/> YES <input type="checkbox"/> NO			If no how can we contact you?
SERVICES: <input type="checkbox"/> Ho'oiikaika <input type="checkbox"/> Dental <input type="checkbox"/> Enabling (Please List):			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	SS#:	DOB:	Ethnicity:
Hawaiian Ancestry: <input type="checkbox"/> less than 1/4 <input type="checkbox"/> 1/4 <input type="checkbox"/> 1/2 <input type="checkbox"/> 3/4 <input type="checkbox"/> Full <input type="checkbox"/> Unknown <input type="checkbox"/> None			
Payor Code			
Client's Health Care Insurance			
<input type="checkbox"/> Self / None	<input type="checkbox"/> Private Insurance _____ # _____		
<input type="checkbox"/> Medicaid # _____	<input type="checkbox"/> Quest <input type="checkbox"/> Kaiser <input type="checkbox"/> Aloha Care <input type="checkbox"/> HMSA # _____		
<input type="checkbox"/> Medicare # _____	<input type="checkbox"/> Other _____ # _____		
Household Information			
Parent/Guardian:			
Last	First	M.I.	
Parent/Guardian Relationship to Client: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other _____			
Street/Mailing Address:		City:	Zip Code:
Home Phone #:		Other Phone #:	
Family Size _____ Income: \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual			
Income Source: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> DSSH <input type="checkbox"/> Family <input type="checkbox"/> SSI/SSDI <input type="checkbox"/> Soc. Security Retirement <input type="checkbox"/> Other: _____ <input type="checkbox"/> None			
Employed: <input type="checkbox"/> Unemployed <input type="checkbox"/> Part time <input type="checkbox"/> Full time		<input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Student	Occupation: <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced			
Living Arrangement: <input type="checkbox"/> Own Home <input type="checkbox"/> Rooming House <input type="checkbox"/> Apartment <input type="checkbox"/> Homeless <input type="checkbox"/> Public Housing <input type="checkbox"/> Rent Home <input type="checkbox"/> Care Home <input type="checkbox"/> Other _____			
Homeless: <input type="checkbox"/> Not homeless <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Transitional <input type="checkbox"/> Doubling Up <input type="checkbox"/> Street <input type="checkbox"/> Other: _____ <input type="checkbox"/> Yes, but unknown How long _____ / _____ to _____ / _____			



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Medical Information	
Doctor Name:	Doctor Address:
Phone #:	Fax #:
Dentist Name:	Dentist Address:
Phone #:	Fax #:

Other Information	
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other	
Interested In: <input type="checkbox"/> Ho`oponopono <input type="checkbox"/> La`au Lapa`au <input type="checkbox"/> Lomilomi <input type="checkbox"/> Not interested <input type="checkbox"/> Undecided/Other	
Referred By: <input type="checkbox"/> Self <input type="checkbox"/> Friend <input type="checkbox"/> Agency <input type="checkbox"/> Family <input type="checkbox"/> Doctor <input type="checkbox"/> Other: _____	Reason for Referral:
Transportation: Do you have access to transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Client Assessment

Please fill in the following information: Ht: _____ Wt: _____

• **Do you use tobacco?** Yes No Product Type: _____ Quantity (Packs)/Day: _____

• **Do you drink alcohol?** Yes No Drinks/Day: _____

• **Personal Safety:**

a) **Do you live alone?** Yes No

c) **Do you have vision or hearing loss?** Yes No

b) **Do you have frequent falls?** Yes No

d) **Do you need assistance with walking?** Yes No

BIO-PSYCHOSOCIAL

• **Are you presently taking any medication** (prescription or over the counter including supplements) **on a regular basis?** Yes No **If yes, please list medications below:** _____

• **Do you have any physical impairment, learning disability or other condition?** Yes No
 If yes, please describe (Briefly). _____

• **Have you experienced any emotional or psychological concerns during the past 2 years?** Yes No
 If yes, please describe (Briefly). _____

• **Have you sought professional treatment for any physical, emotional or psychological illness or concerns during the past 2 years?** Yes No If yes, please describe (Briefly). _____

• **Have ever been treated and/or experienced any problems with alcohol and drugs?** Yes No
 If yes, please describe (Briefly). _____

PLEASE CHECK THE FOLLOWING THAT APPLIES TO YOUR HEALTH:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Obesity | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Cancer Type: _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke Date: _____ | |
| <input type="checkbox"/> Diabetes Type: _____ | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Other: _____ | |

Please list your family medical history: _____



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NHHCS Objectives

1. Do you have medical insurance? Yes No Don't know
2. Do you have dental insurance? Yes No Don't know
3. Do you have drug (prescription) insurance? Yes No Don't know
4. Do you see your medical doctor at least once a year? Yes No Don't know
5. Do you see your dentist twice a year? Yes No Don't know

FOR CHILDREN 3 YEARS OR YOUNGER:

6. Is this child up to date on his/her immunizations? Yes No Don't know

CLIENTS 2 YEARS AND OLDER (if younger than 2 years old, you may stop here):

7. How many servings of fruits and vegetables do you eat a day?
 None less than 5 servings/day 5 more servings/day
 8. On an average, how much exercises do you DAILY? (walking, swimming, aerobic, cycling, etc.)
 None less than 30 minutes/day 30 minutes or more/day not applicable
 9. What kinds of healthcare do you use when ill? (check all that apply)
 Doctor/Medical Clinic Don't go to any healthcare provider
 Traditional Hawaiian Therapy Alternative therapy (aroma, vitamins & minerals, shiatsu, etc.)
 10. When was the last time you visited your healthcare provider?
 Never or refuse to go to any healthcare provider within the past 12 months
 Within the past 2 years 3 or more years ago Don't know
-
11. **Would you like to have a personal one on one consultation with Ke Ola Mamo's:** Yes No
 (check all that apply) Outreach Worker Fitness Trainer Social Worker Nurse Dietician Doctor

Client Declaration

I hereby certify that my child (A) is of Hawaiian/Part-Hawaiian ancestry or (B) is not of Hawaiian/Part-Hawaiian ancestry. **Select (A) or (B).**_____

I hereby authorize the release of the above information to be used for statistical purposes and/or for the receipt of services, which my child may be entitled. All information is kept confidential and the property of Ke Ola Mamo.

I and my child participated in the development of a plan of action and agree to work with the staff of Ke Ola Mamo to attain the set goals. My child will participate in Ke Ola Mamo's programs voluntarily assuming any risks involved.

I, _____, have received a copy of Ke Ola Mamo's Client Rights/Summary of Privacy Practices on behalf of my child. I hereby authorize Ke Ola Mamo to provide any consulting health care professional with information concerning health care, advice, treatment, and/or supplies provided on behalf of my child. This information will be used exclusively for the purpose of carrying out treatment, payment, and/or health care operations.

Keiki Signature (if present): _____ **Date:** _____
Parent/Guardian Signature: _____ **Date:** _____
Intake Worker's Signature: _____ **Date:** _____



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STAFF USE ONLY

TO BE COMPLETED BY STAFF: **B/P:** _____ **BMI:** _____

Body Functions & Structure: No impairment Impairment If impaired, explain _____
Activities & Participation: No difficulty Difficult If difficult, explain _____
Estimated duration of services: 90 days or less 6 months or less 6 months to 1 year 1 year +
Estimated intensity of services provided: Weekly 2x/month Monthly Maintenance
Financial resources: Other: _____ Grant Self-pay Insurance

Enrolled By: _____ Date: _____
 (Name, Title)
 Case Manager Review: _____ Date: _____
 Data-Entered By: _____ Date: _____

KOM Staff Initial & Date of Annual Update: _____ / _____ _____ / _____ _____ / _____