



Doctor Name	Doctor Address
Phone #	FAX #
Dentist Name	Dentist Address
Phone #	FAX #

Primary Language	Understand Hawaiian	Hawaiian Ancestry	Highest Education Level
<input type="checkbox"/> English <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other _____	<input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> Fluent	<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	High School <input type="checkbox"/> Yes <input type="checkbox"/> No College <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A

**EMPLOYED**  
 Full Time     Part-Time     Unemployed     Self Employed     Retired     Student     N/A     Other \_\_\_\_\_

**OCCUPATION**  
 \_\_\_\_\_

**LIVING ARRANGEMENT**

<input type="checkbox"/> Own Home	<input type="checkbox"/> Public Housing
<input type="checkbox"/> Rooming House	<input type="checkbox"/> Rental Home
<input type="checkbox"/> Apartment	<input type="checkbox"/> Care Home
<input type="checkbox"/> Homeless	<input type="checkbox"/> Other _____

**INCOME SOURCE**

<input type="checkbox"/> Self	<input type="checkbox"/> Alimony	<input type="checkbox"/> SSI	<input type="checkbox"/> Other _____
<input type="checkbox"/> Spouse	<input type="checkbox"/> Family	<input type="checkbox"/> No response	<input type="checkbox"/> None
<input type="checkbox"/> DSSH	<input type="checkbox"/> Soc. Security/Pension		

**INTERESTED IN**

<input type="checkbox"/> Ho`oponopono	<input type="checkbox"/> Lomilomi	<input type="checkbox"/> Undecided
<input type="checkbox"/> La`au Lapa`au	<input type="checkbox"/> Not interested	

**PRIMARY HEALTH SERVICES**

<input type="checkbox"/> Physician	<input type="checkbox"/> Hearing Exam	<input type="checkbox"/> Clinic
<input type="checkbox"/> Hospital	<input type="checkbox"/> Family Planning	<input type="checkbox"/> Dental
<input type="checkbox"/> Eye Exam	<input type="checkbox"/> Well Child Services	<input type="checkbox"/> Transportation (HMONO)
		<input type="checkbox"/> Pharmaceuticals
		<input type="checkbox"/> Other _____

**WHO REFERRED YOU**

<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**  
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**VETERAN**

<input type="checkbox"/> Veteran	Veteran Family Member	<input type="checkbox"/> N/A
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**BARRIERS TO SERVICE**

<input type="checkbox"/> Attitudinal	<input type="checkbox"/> Function/Musculoskeletal	<input type="checkbox"/> Medical
<input type="checkbox"/> Cognitive	<input type="checkbox"/> Safety	<input type="checkbox"/> Surgical

**EXPLANATION**  
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