Saginaw Chippewa Indian Tribe

Healing to Wellness

Intake Form

DEMOGRAPHICS:

First Name: _____ Middle: _____ Last Name: _____
Address: _____
Primary Phone Number: _____ Secondary Phone Number: _____
Sex: ☐ F or ☐ M Age: ____ Date of Birth: _____/_____/____
Driver's License #: _____ State ID #: _____
Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____
Spirituality: ☐Traditional ☐Christianity ☐None ☐Other (specify): _____
What is your relationship status? ☐Married ☐Divorced ☐Single
☐Separated ☐Widowed ☐In a Relationship
Emergency Contact Person: _____ Phone #: _____
Name of Significant Other: _____ Phone #: _____

Do you have children? ☐Yes or ☐No How many children under 18 do you have? _____
Have you ever served in the military? ☐Yes or ☐No If YES, what branch? _____
Do you have reliable transportation? ☐Yes or ☐No

TRIBAL AFFILIATION:

SCIT ☐ Member or ☐ Descendant Member #: _____
Other: ☐ Member or ☐ Descendant Name of Tribe: _____
Address: _____
Phone Number: _____ Contact Person: _____

HOUSING:

Living Conditions: ☐ Independent ☐ Dependent: Family/Friends ☐ Homeless ☐Shelter
☐Other (explain): _____
If Dependent, homeless, and/or shelter – please state the following information:
Contact Name: _____ Phone Number: _____
How many times have you moved in the past 3 years? _____ Reason(s): _____
_____
Have you ever received housing assistance: ☐Yes or ☐No
If not, what housing resources have you contacted for assistance?

1.) Name of Organization: _____
Contact Person: _____ Phone #: _____
2.) Name of Organization: _____

Contact Person: _____ Phone #: _____

3.) Name of Organization: _____

Contact Person: _____ Phone #: _____

LEGAL INFORMATION:

Most recent criminal offense: _____

County: _____ Date of offense: _____

Are you on any of the following: ☐Probation ☐Parole ☐Bond

Are you aware of any warrants for your arrest? ☐Yes or ☐No If YES, briefly explain: ____

_____

Do you have any pending charges? ☐Yes or ☐No If YES, briefly explain: _____

_____

Criminal Offense History:

1.) Offense: _____ County: _____ Year: _____ Charged: ☐Yes or ☐No

2.) Offense: _____ County: _____ Year: _____ Charged: ☐Yes or ☐No

3.) Offense: _____ County: _____ Year: _____ Charged: ☐Yes or ☐No

Have you ever been convicted of Domestic Violence? ☐Yes or ☐No

If YES, provide the following: Date: _____ County: _____ State: _____

SUBSTANCE USE HISTORY:

1. In the past 30 days, what substance, if any, have you used (includes tobacco products)? _____
   a. Number of days used: _____
   b. How? ☐Oral ☐Intranasal ☐Vaping ☐Smoking ☐Non IV Injection ☐IV Injection
2. In the past 30 days, what substance, if any, have you used (includes tobacco products)? _____
   a. Number of days used: _____
   b. How? ☐Oral ☐Intranasal ☐Vaping ☐Smoking ☐Non IV Injection ☐IV Injection
3. In the past 30 days, what substance, if any, have you used (includes tobacco products)? _____
   a. Number of days used: _____
   b. How? ☐Oral ☐Intranasal ☐Vaping ☐Smoking ☐Non IV Injection ☐IV Injection
4. What is your **primary** substance you use? _____
   a. How often daily/weekly? _____ Route: _____
   b. Have you received Medically Assisted Treatment? ☐Yes or ☐No
5. What is your **secondary** substance you use? _____
   a. How often daily/weekly? _____ Route: _____
   b. Have you received Medically Assisted Treatment? ☐Yes or ☐No
6. What is your **tertiary** substance you use? _____

a. How often daily/weekly? _____ Route: _____
b. Have you received Medically Assisted Treatment? ☐Yes or ☐No

7. Have you ever received inpatient treatment for your Substance Use? ☐Yes or ☐No
8. If YES to inpatient treatment please list the following information:
   a. Organization Name: _____ Year: _____
      i. How long were in treatment for? _____
   b. Organization Name: _____ Year: _____
      i. How long were in treatment for? _____
   c. Organization Name: _____ Year: _____
      i. How long were in treatment for? _____

MEDICAL INFORMATION:

1. Name of insurance company: _____ Phone #: _____
   Group #:_____ Name of Carrier: _____
2. Do you have any disabilities? ☐Yes or ☐No If YES, name of disability: _____
   If you answered YES, list of prescriptions you are currently taking: _____
   _____
3. Have you ever been diagnosed with a mental health illness? ☐Yes or ☐No
   If YES, list of diagnosis: _____
   If YES, list prescriptions currently taking: _____
4. Have you received medical care in the past 30 days? ☐Yes or ☐No

EDUCATION, EMPLOYMENT, AND INCOME:

1.) Are you currently enrolled in school ☐Yes or ☐No Highest grade completed: _____
   a. If YES, what school are you enrolled in? _____
2.) Are you currently working ☐Full time - ☐Part-Time - ☐Unemployed - ☐Self-employed
   ☐Other, explain: _____
   If YES, Name of employer: _____
   Phone #: _____ Contact Person: _____
   Occupational Title: _____
3.) Do you have enough money to provide the following (check all that apply):
   ☐Food ☐Shelter ☐Clothing ☐Transportation ☐Childcare
   ☐Utilities ☐Health Insurance

CULTURAL AND SOCIAL CONNECTEDNESS:

1.) Do you have your Anishinabek name? ☐Yes or ☐No
   a. If YES, what is your Anishinabek name and what is the meaning?
      _____
   b. If NO, would you like to receive your Anishinabek name? ☐Yes or ☐No
2.) Have ever participated in a sweat lodge? ☐Yes or ☐No
3.) Have you ordered your Eagle feathers? ☐Yes or ☐No
4.) Do you or have you ever participated in cultural activities? ☐Yes or ☐No
5.) List cultural activities you participate in (past and present): _____

_____ _____

_____ _____

6.) If you have not participated, list of cultural activities you are interested in: _____

_____ _____

_____ _____

7.) Do you have healthy interactions with your family and/or your friends? ☐Yes or ☐No

8.) Do you need to change your social connections or places to work on yourself? ☐Yes or ☐No

9.) Do you have a healthy support system? ☐Yes or ☐No

The information provided in this application is true to the best of my knowledge. I understand that if any information provided is not true I may be excluded from the program.

Signature of Applicant: Date:

Signature of AHTW Staff: Date: