HUDSON HEALTH SERVICES, INC.

1506 Harting Drive
P.O. Box 1096
Salisbury, MD 21801
Phone: (410) 219-9000
Fax: (410) 219-5112

INITIAL CONTACT FORM (ICF)

Referral Source/ Name : _____
Telephone of Referring Source : _____

Patient Name _____
Social Security Number _____
Date of Birth _____ **Current Age:** _____
Sex : Male Female If Female: Pregnant Yes No Due Date:_____
Race: White African American Hispanic Other_____
Patient Address :
Street_____
City_____**State**_____**Zip**_____
Patient Telephone or Contact Number(H)_____
(c) _____
Marital Status: Married Single Separated Divorced Widow/Widower **# of children**_____
Military Active **/** Veteran /Never in Military **/**Unknown **Years of Service**_____
Highest Education Level Completed: _____ **GED or Diploma**
Employment Status Employed Unemployed Homemaker Retired Disabilty/Social Security
Living arrangements : Homeless/Shelter Spouse / Family Parents Other _____

TREATMENT HISTORY		**Number of Times**	**Date**
Inpatient Treatment	Yes No		
Outpatient	Yes No		
Detoxification Only	Yes No		
Methadone Maintenance	Yes No	**Dosage-**	
Suboxone Maintenance	Yes No	**Dosage-**	

SUBSTANCE USE HISTORY

Substance	**Route**	**Frequency**	**Amount Using**	**Age of 1st Use**	**Date of last use**
Tobacco User YES NO					

History of Seizures YES NO	**History of Overdose** YES NO
History of DT's YES NO	**History of Blackouts** YES NO
Does Patient Need Detoxification Services YES NO	

MEDICAL and MENTAL HEALTH HISTORY

Condition/Diagnosis (Medical and Psychiatric)	**Date of Diagnosis**	**Is Condition Stable?**	**Physician Name / or Mental Health Provider Name**
Open Wounds/Abcess			

Medications	Dosage/Frequency	Reason for Medication

Do you have any current issues with :**Head Lice** Yes or No **Scabies** Yes or No **Bed Bugs** Yes or No

History of Past Suicide Attempts YES NO Date of Last Attempt _____
Current Suicidal Thoughts: Yes No **Current Homicidal Thoughts:** Yes No
History of Inpatient Mental Health Treatment YES NO Date (s) _____

Travel Screening

- **Has patient or anyone they have been in contact with been out of the country or traveled in the U.S. the last month?** YES NO
- **If YES please continue:**
  - **To which country/city has the patient or other party traveled?**

Country/State	City	Date arrived	Date departed

  - **Are any symptoms present? fever /cough/Shortness of Breath**

LEGAL HISTORY

- **Current Charges**: YES NO **Registered Sex Offender:** YES NO
- **Past Charges**: YES NO
- **Is Client on Parole or Probation**: YES NO
- **Name of Parole Officer** _____
- **Upcoming Court Dates** YES NO Date : _____

Insurance Information

Insurance / Managed Care Name	
Policy Number / M. A. Number	
Telephone Number of Insurance Company	
Policy Holder's name (if different than patient)	
Policy Holder's D.O.B and Social Security Number	

Appointment Date at Hudson Health Services, Inc.
Date _____Time _____