HUDSON HEALTH SERVICES, INC.

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P.O. Box 1096
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Phone: (410) 219-9000
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INITIAL CONTACT FORM (ICF)

Patient Name _____
Social Security Number _____
Date of Birth _____ **Current Age:** _____
Sex : **Male** ☐ **Female** ☐ **If Female: Pregnant Yes** ☐ **No** ☐ **Due Date:**_____
Race: **Caucasian** ☐ **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** ☐ **Diploma** ☐
Employment : Employed ☐ Unemployed ☐ Homemaker ☐ Retired ☐ Disabilty/Social Security ☐
Living arrangements : Homeless ☐ Shelter ☐ Spouse ☐ Family ☐ Parents ☐ Other_____

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

SUBSTANCE USE HISTORY

Please include any additional info for this section here:

Substance	Route	Frequency	Amount Using	Age of 1st Use	Date of last use
Methadone/Suboxone					
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 or Abscesses			

Medications	Dosage/Frequency	Reason for Medication

Do you have current issues with **head lice** ( ) **scabies** ( ) **bed bugs** ( )?

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): _____

FOREIGN TRAVEL SCREENING

- **Has patient or anyone they have been in contact with been out of the country in the last month?** YES ☐ NO ☐
- **If yes please continue**

Country	City	Date Arrived	Date Departed

- **Are any symptoms present?** Fever/profuse sweating/diarrhea/bleeding

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	

Referral Source/ Name : _____

Telephone of Referring Source : _____