



1505 Emerson Avenue
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 Disability/Social Security
Living arrangements : Homeless/Shelter Spouse / Family Parents Other _____

TREATMENT HISTORY	YES	NO	Number of Times	Date
Inpatient Treatment				
Outpatient				
Detoxification Only				
Methadone Maintenance			Dosage-	
Suboxone Maintenance			Dosage-	

SUBSTANCE USE HISTORY

Substance	Route	Frequency	Amount Using	Age of 1 st 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

Medications	Dosage/Frequency	Reason for Medication

Do you have any 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) _____

COVID Screening

- ❖ **Has Patient been around anyone with the COVID19 virus?** YES NO
- ❖ **Has Patient ever tested positive for the COVID19 virus?** YES NO
- **Are any symptoms present?** **fever** **cough** **shortness of breath**
 loss of taste or smell **fatigue** **nausea** **vomiting**
 fever **diarrhea** **None**

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 _____