HUDSON Behavioral Health

1505 Emerson Avenue
Salisbury, MD 21801
Phone: (410) 219-9000
Fax: (410) 219-5112

INITIAL CONTACT FORM (ICF)

Referral Source / Name / "How did you hear about Hudson?"

_____

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	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 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 or Abscess Yes or No			
Can you walk & get around unassisted?			

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 _____