1505 Emerson Avenue
Salisbury, MD 21801
Phone: (410) 219-9000
Inpatient Fax: (410) 219-5112
Housing Fax: (443) 736-4266

***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

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 _____________