HUDSON
Behavioral Health

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INITIAL CONTACT FORM (ICF)

Referral Source/ Name & Phone : _____/_____
New Client: ☐ **or** **Repeat Client:** ☐
Patient Name:_____ **Social Security #:**_____
Date of Birth _____ **Current Age:** _____
Patient Telephone Number (H):_____ **(C):** _____
Gender : ☐ **Male** ☐ **Female** **Other:** _____ **Pregnant:** ☐ No ☐ Yes, **Due Date:**_____
Race: ☐ **White** ☐ **African American** ☐ **Hispanic** ☐ **Other:**_____
Patient Address : Street_____
City: _____ **State:** _____ **Zip:**_____

# of children:_____ **Marital Status:** ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widow/Widower
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 _____
Any type of Substance, MAT, or Mental Health Treatment in the last 90 days? _____ **In the last 30 days?** _____
If yes, where/type of treatment:_____

TREATMENT HISTORY	NO or YES	Number of Times	Most Recent 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? ☐ NO ☐ YES					

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

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 ☐NO or ☐YES **Scabies** ☐ NO or ☐YES **Bed Bugs** ☐NO or ☐YES
Are you able to walk unassisted? ☐NO or ☐YES **Do you have any issues with incontinence?** ☐NO or ☐YES
Do you have any open wounds / cuts / burns? ☐NO or ☐YES, (If yes, circle all applicable)

History of Past Suicide Attempts ☐NO or ☐YES (if marked yes, please conduct abbreviated Columbia screening)
Date of Last Attempt: _____
Current Suicidal Thoughts: ☐NO or ☐YES **Current Homicidal Thoughts:** ☐ NO or ☐YES
History of Inpatient Mental Health Treatment ☐NO or ☐ YES, **Date(s)** _____
Audio/Visual/Tactile hallucinations? ☐NO or ☐YES, **Current / Past, Last time symptoms experienced**: _____
Self harm? ☐NO or ☐YES,**Method of self harm:** _____ **Current / Past, Last time**: _____

Infection Control

- **Have you had or been exposed to any infection within the last 10 days (ex.flu,strep,skin infections,UTI's, organ infections,abcesses,Covid-19)?** ☐NO ☐ YES, _____
- **Are any symptoms present?** (Circle all applicable) **fever /cough / shortness of breath / loss of taste or Smell / fatigue / nausea / vomiting / diarrhea / NONE**

LEGAL HISTORY

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

Insurance Information (PRIMARY)

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	

Insurance Information (SECONDARY)

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 _____