HUDSON
Behavioral Health
CELEBRATING 45 YEARS!

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Housing Initial Contact Form (ICF)

Referral Source/Name & Phone: _____ /_____
☐ New Client ☐ 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 Seeking Retired Disabled/Social Security
Living Arrangements: Homeless/Shelter Spouse/Family Parents Other: _____
Any type of Substance, MAT, or Mental Health Treatment in the last 90 days? _____ 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	Route	Frequency	Amount Using	Age of 1st use	Date of last use

Tobacco User? No Yes ☐
Any other Addictive disorders? NO or YES If yes, list _____

History of Seizures NO or YES ☐ ☐ History of Overdose NO or YES ☐ ☐

History of DT's NO or YES ☐ History of Blackouts NO or YES ☐

Medical and Mental Health History

Condition/Diagnosis Medical and Psychiatric	Date of Diagnosis	Is Condition Stable?	Physician Name/ or Mental Health Provider Name

Name of Primary Care Physician: _____

Address of Primary Care Physician: _____

Date of Last Physical: _____ Allergies: _____

Medications	Dosage / Frequency	Reason for Medication

Does Patient have any Allergies NO or YES If yes, list allergies: _____

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 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 If yes, Date(s) _____

Audio/Visual/Tactile Hallucinations? NO or YES Current/Past, Lifetime symptoms experienced: _____

_____

Self-Harm NO or YES If yes, Method of Self-Harm: _____ Current/Past, Last Time: _____

Infection Control

Have you been exposed to any infection within the last 10 days (ex. Flu, strep, skin infections, UTI's, organ infections, abscesses, Covid-19)? NO or YES If Yes, list:

_____

Are there 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 IF YES, List charges _____

Is Patient on Parole or Probation NO or YES If yes county and name of Agent: _____

Pending Court Dates? NO or YES Dates and County: _____

Insurance Information

Insurance/ Managed Care Name	
Policy Number/ MA Number	
Policy Holder's Name (If different than patient)	
Policy Holder's DOB and SS#	