Julia Gerhardt, LCSW, LLC
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Boise, ID 83704
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PATIENT HEALTH DATA

Name _____ Birth Date _____ Age _____ Sex M F
Parent/Guardian _____Family Physician _____Date Last Physical _____
Current MedicalConcerns/Treatments_____
_____
_____

Family History: Has anyone in your family had a history of:

Nervousness or Mental Illness	Y	N	If yes, who_____
Alcohol or Drug Use	Y	N	If yes, who_____
Diabetes	Y	N	If yes, who_____

Prior Psychiatric/Psychological Treatment:
Psychiatric Hospitalizations: (dates and reasons) _____
Prior Psychiatrists:(dates)_____
Prior Therapists: (dates)_____

Health History: (circle all that apply)

Smoke	Y	N	Packs per day _____		Seizures	Y	N
					Loss of consciousness	Y	N
Drug Use:			How much?	How often?	Recurring headaches	Y	N
Marijuana	Y	N	_____	_____	Vertigo/dizziness	Y	N
Cocaine	Y	N	_____	_____	Bed wetting	Y	N
LSD	Y	N	_____	_____	Cancer	Y	N
PCP	Y	N	_____	_____	Blood disease	Y	N
Stimulants	Y	N	_____	_____	Skin ulcers/lesions	Y	N
Alcohol	Y	N	_____	_____	Current nausea/vomiting	Y	N
Caffeine	Y	N	_____	_____	Recent loss/death in family	Y	N
History of Physical Abuse			Y	N	Change in appetite	Y	N
History of Sexual Abuse			Y	N	Stomach ulcers	Y	N
Psychological abuse			Y	N	Stroke	Y	N
Thyroid problem			Y	N	High blood pressure	Y	N
Fainting			Y	N	Chest pain	Y	N
Shortness of breath			Y	N	Divorce	Y	N
Possible verifiable pregnancy			Y	N	Motor difficulties	Y	N
Liver disease			Y	N	Head injury	Y	N
Sleep difficulties			Y	N	Other _____		

Current medications: _____
_____
List known allergies: _____
List serious medication side effects: _____

This medical history is complete and correct based on my knowledge. I authorize the release of any Protected Health Information (PHI) necessary and authorize payment of medical/mental health benefits to the provider from my insurance carrier. Julia Gerhardt, LCSW, LLC has advised me that certain services provided to me by this office may not be reimbursed by my insurance. I have elected to proceed and have those services provided to me with full knowledge and understanding that any charges incurred, to include telephone contacts, time spent on written requests/reports, and client no shows/late cancellations, are my responsibility regardless of insurance status. At my request a copy of this disclosure will be provided and explained to me. I request payment of authorized private insurance benefits for any and all services furnished to me be made to Julia Gerhardt, LCSW, LLC on my behalf. I consent to authorize Julia Gerhardt, LCSW, LLC to provide pertinent information to bill my insurance benefits and any other PHI concerning me to release information needed to determine those benefits payable for related services.

Client Signature: _____ Date: _____
Parent or Guardian: _____