Total Wellness Consultants
Dr. Rebecca S. Harvey

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Suite 460
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Confidential Client Information

Name:
Date of Birth:
Referred by:
Street Address:
City:
Zip code:

BCBS Subscriber #:
Occupation:
Employer:

Preferred Phone:
Email:

Okay to text message: YES NO
Okay to email: YES NO
Okay to leave voicemail: YES NO

Marital Status:
Number of Previous Marriages:

Number of Children:
Number of Children:

Previous therapy? ( )Yes ( ) No When:
Reason:
Previous Therapist:

For how long?
Was it effective?

Current Medications:

Primary Doctor or Psychiatrist:

How long have you been taking?
Reason:

Address:
Telephone:

Date of Last Exam:

Any Family History of Mental Illness: ( )Yes ( )No ( ) Unknown
If yes, whom?: When?: Hospitalized?:
Diagnosis if known:

Are You Depressed? ( ) Yes ( ) No
Describe Reason(s) for Seeking Therapy:

Emergency Contact:
Telephone Number(s):
Authorization to Notify During an
Emergency?: ( ) Yes ( ) No

Your Signature: _____ Today's Date: _____