

Audrey A. Simmons, LMHC

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CLIENT PROFILE

NAME: _____

ADDRESS: _____

EMAIL ADDRESS: _____

PHONE: _____ **HOME** _____ **CELL** _____ **WORK**

DATE OF BIRTH: _____

REFERRAL SOURCE: _____ **PHONE:** _____

FAMILY PHYSICIAN: _____ **PHONE:** _____

MEDICATIONS: _____

ALLERGIES: _____

EMERGENCY CONTACT: _____ **PHONE:** _____

I have received and understand the Welcome letter outlining confidentiality, scheduling, cancellation policies and fees and agree to adhere to these procedures.

Client Signature: _____ **Date:** _____

Counselor Signature: _____ **Date:** _____