Client Profile Form for Robin Manning PhD @ Health Care Alternatives

Client Name_____Today's date_____

Birthday_____Age_____Weight_____Height_____

Address_____City_____Zip_____

Cell phone_____other_____ E-mail_____
Favorite way to be contacted (circle one) text - e-mail- phone call on cell or other?

Circle One: Married Single Divorced Widow(er)

Occupation_____ Top Four Complaints 1._____

2._____3._____4._____

Who can I thank for referring you?_____
Are you under a Physicians Care?____Name Of Primary care Doctor_____
Medications & dose you are currently on_____
Vitamins' & Herbs?_____
Surgeries & Dates_____
Do you exercise?_____How Often?_____ Which exercises do you enjoy?_____

Family History: Include Current Age & Current Health Status of each person. If deceased **what was the age, cause & year deceased** ---- include names

Mother_____Father_____

Siblings_____

Children_____

Spouse_____

~~I clearly understand that all services rendered are my responsibility and payment is expected at the time of service & Dr. Manning is a "Cash Practice" - No health insurance

Client Signature_____ Date_____

If under 18 years of age, parent or guardian

signature_____