Client Profile Form for Robin James-Manning PhD @ Health Care Alternatives LLC

Name____ Today's date______________
Birthday_________________Age___________Weight___________Height__________
Address___________________________________City_______________Zip________
Phone__________________ Cell________________E-Mail______________________
Married______Single______Divorced_____Widow(er)____# of Children___________
Occupation______________________________Top Four Complaints 1.____________
2.______________________3.___________________4.______________________
Who can I thank for referring you?____
Are you under a Physician Care?_________Who?_______________________________
Reason you are under a Doctors Care & for how long?____________________________
Medications you are currently taking____
Vitamins' & Herbs?____
Surgeries & Dates____
Do you exercise?_________How Often?____________________What type of exercise
or sports do you enjoy ?____
Family History: Include Current Age & Health Status of each. If deceased **what was the cause** and at what age include names
Mother_______________________________Father______________________________
Siblings____
Children____
Spouse____
How is your sleep?____
**I clearly understand that all services rendered are my responsibility and payment is expected at the time of service.Client Signature___________________________Date____________
If under 18 years of age, parent or guardian signature_______________________________