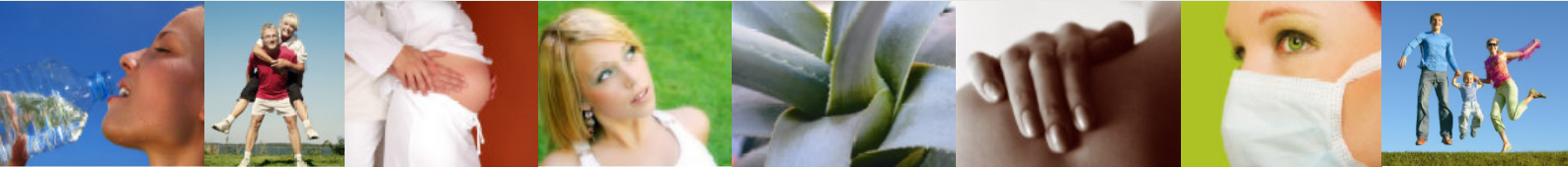


Synergy Clinic . Com NEW CLIENT Information Form



FAMILY MEDICAL HISTORY

Has ANYONE in your family had any of the following? (tick box for yes)

Please Specify Who (mum, dad, grandad) + Age of onset

- Allergies/Hayfever _____
- Alcoholism _____
- Alzheimer's _____
- Arthritis _____
- Asthma _____
- Cancer- Bowel _____
- Cancer- Breast _____
- Cancer- Liver _____
- Cancer- Lung _____
- Cancer- Prostrate _____
- Other Cancer _____
- Diabetes _____
- Epilepsy _____
- Heart Disease _____
- High Blood Pressure _____
- High Cholesterol _____
- Infertility _____
- Low Blood Pressure _____
- Menstrual/Menopausal Problems _____
- Mental Conditions _____
- Obesity _____
- Sinus _____
- Skin Complaints _____
- Thyroid Conditions _____

EMERGENCY CONTACT DETAILS

In case of emergency, please contact _____ (full name)

Phone (w) _____ Phone (mobile) _____ Phone (h) _____

GP name: _____ Phone _____

Other health practitioners (please specify profession)

Name _____ Profession _____ Phone _____

Name _____ Profession _____ Phone _____

LATE/CANCELLATION POLICY

I understand that all consults will end at their scheduled time (even if I arrive late). I understand that a minimum of 48 hours notice is required for cancellations of health appraisals + repeat visits and that 3 working days notice is required for contraception or natural fertility program appointments and that cancellation fees may be charged if I give less than the required notice.

ALL OF THE ABOVE INFORMATION IS TRUE + CORRECT + I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM MY PRACTITIONER OF ANY CHANGES TO THIS.

SIGNED _____

DATE _____