

A Therapeutic Effect

Personal Data

Patient's Name: _____	Today's Date: _____
Address: _____ _____	Phone Number: <small>daytime</small> _____
email: _____	<small>evening</small> _____
Date of Birth: _____ / _____ / _____ <small>month day year</small>	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Occupation: _____	Referred by: _____
Emergency Contact: _____	Phone Number: <small>daytime</small> _____
Relationship: _____	<small>evening</small> _____

Are you currently under a Physician's care? Yes No

If yes, please explain: _____

Please list any past or present injuries, accidents, or medical treatment including surgeries:

Are you pregnant? Yes No *If yes, some services may not be administered.*

Please list all known allergies: _____

Please list all medications and supplements you are taking: _____

CANCELLATION POLICY

If you are unable to keep your appointment - for any reason - please give us as much notice as possible. For appointments broken with less than 12 hours notice, we reserve the right to charge 50% of the standard fee. Appointments that no show will be charged in full to cover the therapist's time.

CONTRAINDICATIONS - If you have any of the following conditions Synergie™ CANNOT be done (circle all that apply)

Pregnancy	Hemophilia	Deep Vein Thrombosis / Thrombophlebitis (phlebitis)
Lymphedema	Multiple Sclerosis	Recently Diagnosed Cancer
Severe cardiac disease (e.g. uncontrolled hypertension, valve disease)		

Please sign below to acknowledge that you have reviewed the contraindication list

Client / Responsible Party Signature: _____

Date: _____

WARNING - if you have the following condition, the Synergie™ treatment should only be administered with caution:

Using Prescribed anti-coagulant drugs (coumadin, heparin, aspirin based products) Yes No

PRECAUTIONS - If you have any of the following conditions, YOU MAY BE ABLE TO RECEIVE A Synergie™ TREATMENT UNDER CERTAIN LIMITATIONS (circle all that apply)

Cancer (not recent)	Diabetes	Epilepsy	Skin Disorders (ie open sores, infections, psoriasis)
Eating Disorder	Fasciitis, Tendonitis	Body Piercings	Skin that is extremely sensitive or bruises easily
High Blood Pressure	Mesh Surgery Repair	Menses	Systemic Infection (including swollen glands)
Recent Scarring	"Spider" Veins	Varicose Veins	Hernia (previous hernia or hernia surgery)
Heart Pacemaker	Diagnosed Heart Condition	Circulatory Problems	Bone Fractures (unhealed, bone deformities, or metal implants)
Surgical Procedures (prior six weeks including Caesarean Section or Liposuction)			
Any other short-term or chronic illness or condition (specify): _____			

Please sign below to acknowledge that you have reviewed the contraindication list

Client / Responsible Party Signature: _____

Date: _____

Client Acknowledgment

- I have met with my technician to discuss the Synergie Lifestyle System™. I fully understand the information regarding the Synergie™ system.
- I have been given the opportunity to have all of my questions answered with regards to the Synergie Lifestyle System™
- I authorize and give consent to allow the technician to administer Synergie AMS treatments upon my person
- I am aware that individual results may vary and no guarantees or promises have been made between the technician or consultant and myself.
- I understand that my information or results will not be published without prior consent.
- I understand that these treatments may involve certain risks (i.e. bruising, redness, sensitive reaction) and I fully accept all responsibilities regarding these risks.
- I acknowledge and consent to be photographed for purposes of treatment monitoring and progress evaluation.

Check one of the following boxes:

- I have reviewed the contraindications on this form and I am not subject to any of those conditions.
- I have reviewed the precautions and if necessary provided a doctor's approval note to allow me to receive treatments.
- I have answered truthfully all questions on this form.

Client's Signature: _____

Date _____

Client's Printed Name: _____

Technician's Signature: _____

Date _____

Technician's Printed Name: _____