Serenity Health & Wellness Center

www.serenitywellness1.com

Client Information (please print)

Name: ______________________________________

Address: ____________________________________City: ___________________State: ______Zip: _________

Cell Phone*: (______)________________________ Secondary Phone: (______)_________________________

Email Address*: ______________________________________

Date of Birth: ______________________________ Occupation: ______________________________________

 Male Female Pregnant: □ Yes, Weeks:_________ No □

How did you hear about Serenity? (Check ALL that Apply)

 Radio

 Facebook

 Internet (Google, Yelp, Yahoo)

 Serenity Newsletter

 Serenity Text

 Print Ad/Magazine (Please Specify): ____

 Community/Charity Event: ____

 Physician or Health Care Provider: ____

 Friend/Relative:____

 Employee Referral: ____

 Gift Certificate

 Other: ____

Primary Care Physician: ____

Symptoms/Treatment Information (mandatory)

Do you have any diagnosed medical conditions? No Yes, please explain: ___________________________

____

Are you currently taking any medications? No Yes, please list: ____________________________________

____

Are you currently experiencing any physical pain or discomfort? No Yes, please explain: _____________

____

Are there any health-related conditions, concerns or questions that you wish to disclose or ask prior to your service? ____

Release Authorization for Treatment

I authorize wellness and/or aesthetic treatment provided by Serenity. I have answered the health related questions on this form honestly and completely. Though licensed in his or her specific service being provided at Serenity, I understand that my Serenity therapist is not a medical physician or doctor and cannot diagnose or prescribe any medications, treatments or services. I understand that Serenity and my therapist are not liable for any unforeseen medical issues that I may experience or complications that may arise that could be related to an undiagnosed, pre-existing medical condition prior to or after my treatment. I will disclose any concerns; health related or otherwise as well as discuss any pre-existing conditions to my therapist prior to receiving a treatment. I understand that I am responsible for my service charges at the time of service.

»Client Signature: ____ Date: _______________________

(Parent/Guardian if patient is a minor)

Cancelation Policy

If you need to cancel or reschedule your appointment, please give us at least a 12 hour notice prior to your service. This is a courtesy to our therapist and will enable us to accommodate other clients. If you cancel your appointment within the 12 hours before your scheduled service, there will be a $25 fee per person, per service. for Life Coaching or Colon Hydrotherapy appointments there will be a 50% service fee. We appreciate your cooperation and your business.

»___________________________ (Client Initial)