



Client Information: (please print)

Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Email Address\*: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Male  Female Pregnant:  Yes, Weeks: \_\_\_\_\_ No

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

Radio  Facebook  Internet  Gift Certificate  Serenity Newsletter  Serenity Text

Print Ad/Magazine (Please Specify): \_\_\_\_\_

Community/Charity Event: \_\_\_\_\_

Friend/Relative: \_\_\_\_\_

Employee Referral: \_\_\_\_\_

Other: \_\_\_\_\_

**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. Although precautions are being taken, I understand that there is some inherent risk in relation to the possible spread of COVID-19. If contracted, I will not hold Serenity Health & Wellness Center or the service provider accountable.

»Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent/Guardian if patient is a minor)