Serenity Health & Wellness Center
1685 Lance Pointe Drive
Maumee, Ohio 43537
(419) 891-2181
www.serenityhealthmaumee.com

Client Information (please print)

Name: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Cell Phone*: (_____)_____ **Provider**: AT&T Sprint T-Mobile Verizon Other:_____

Secondary Phone: (_____)_____ **Email Address***: _____

*Serenity is transitioning to Text and E-mail appointment reminders.

Date of Birth: _____ **Occupation**: _____

Sex (please check): ☐ Male ☐ Female **Pregnant**: ☐ Yes, Weeks:_____ ☐ No ☐ Possibly

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

☐ Friend/Relative: _____

☐ Serenity Website ☐ Facebook ☐ Twitter ☐ Yelp ☐ Toledo City Paper ☐ SpaFinder ☐ Serenity's E-Newsletter

☐ Other Print Advertisement: _____

☐ Employee Referral: _____

☐ Physician or Health Care Provider: _____

☐ Community/Charity Event: _____

☐ Other: _____

Physician

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? _____

Injury Specific Information (if applicable)

Are you injuries related to an accident? □ No □ Yes; Date of Accident: _____

Was the accident automobile related? □ No □ Yes; State in which accident occurred: _____

Are your symptoms employment related? □ No □ Yes

Is there a Workers Compensation Claim? □ No □ Yes, BWC Claim #_____

Employer at the time of injury: _____

Employer Address: _____

Emergency Contact Information

Emergency Contact: _____ Phone Number: _____

Relationship: _____Contact Address: _____

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)

Cancellation Policy

If you need to cancel or reschedule you appointment, please give us at least 12 hours notice prior to your service. This is a courtesy to our therapist and will enable us to accommodate other clients. There will be a 50% service fee charged to the client if a cancellation call does not take place on the first occurrence and 100% service fee thereafter. Thank you for your cooperation. We appreciate your business.

•_____ **(Client Initial)**