Serenity Health & Wellness Center

www.serenitywellness1.com

Client Information (please print)

Name: _____

Address: _____City: _____State: _____Zip: _____

Cell Phone*: (_____)_____ Secondary Phone: (_____)_____

Cell Phone Carrier for Appointment Reminder Text Messages: _____

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? _____

Emergency Contact Information

Emergency Contact: _____ Relationship: _____Contact Number: _____

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)