

Serenity Day Spa

Name _____ Date of Birth _____

Mailing Address _____

Town _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail _____

Occupation _____

How did you hear about us? _____

What is your goal for today's visit? _____

Are you currently under a doctor's care for any kind of medical treatment?

Are you using any topical or oral medications?

Please indicate any and all physical or emotional conditions you have at this time and also please update us if any changes in your physical state occur as they may affect or be affected by treatments you receive here.

I understand that Serenity's therapists do not diagnose medical conditions. I certify that I have given a complete and accurate medical history and will inform my therapist if any changes in my condition occur. I understand that the modalities used by my therapist are meant to reduce stress, tension and pain but do not replace medical treatments. We reserve the right to charge stated rates for any treatment scheduled if the appointment is missed without notice at least 24 hours in advance, and to refuse scheduling of new treatment to any individual who fails to pay for such missed appointments.

Client signature _____ Date _____