Lake Norman Salt Spa

Client Information & Disclosure Form

Client's Name *(Last, First)*: _____

Child's Name(s) (ONLY for clients under 14) _____ Birth date(s): _____

Address: _____

City _____ State _____ Zip code _____

Email: _____

Primary Phone: _____ Birth date: _____

Emergency Contact *(Name)*: _____ Relationship: _____ Phone: _____

How did you hear about us? *(Circle all that apply)*

Google Facebook Signage Referral *(Name)* _____

Other _____

Reason for Salt Therapy Use (check all that apply, including personal history)

- ☐ Acne
- ☐ Allergies
- ☐ Anxiety/Stress
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Sinus/Ear Infection
- ☐ Chronic Ear, Nose, Throat
- ☐ Colds & Flu
- ☐ COPD
- ☐ Cough
- ☐ Cystic Fibrosis
- ☐ Depression
- ☐ Dermatitis/Eczema/Rashes
- ☐ Ear Ringing
- ☐ Earache/Ear Infections
- ☐ Emphysema
- ☐ Fatigue
- ☐ General Health & Wellness
- ☐ Hay Fever
- ☐ Increase Lung Capacity (Athletes & Musicians)
- ☐ Laryngitis
- ☐ Migraines
- ☐ Mood Swings
- ☐ Neurodevelopment Disorders
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Pulmonary Fibrosis
- ☐ Relaxation
- ☐ Respiratory Infections
- ☐ Rhinitis
- ☐ Rosacea
- ☐ Runny Nose
- ☐ Shortness of Breath
- ☐ Sinusitis
- ☐ Smoker's Cough
- ☐ Snoring/Sleep Apnea
- ☐ Sore Throat
- ☐ Stuffiness
- ☐ Tonsillitis
- ☐ Trouble Sleeping
- ☐ Wheezing
- ☐ Other:
- ☐ Other:

Have you had a fever in the last 48 hours? *(Circle)* Yes / No

I confirm I am not presenting any of the following symptoms of COVID-19 listed-*Temperate above 98.7°, Shortness of breath, Loss* of *smell or taste, Dry cough, Sore throat*. Nor have I been around anyone with these symptoms in the last 10 days. *Initial:* _____

Continue to backside

Consent & Release for Salt & Infrared Sauna Therapy

Check any symptoms you are ***currently*** experiencing. Salt therapy **should NOT** be undertaken if you are currently experiencing any of the following:

- ☐ Active Tuberculosis
- ☐ Acute Inflammatory Disease
- ☐ Acute Stage of Respiratory Diseases
- ☐ Any Internal Disease in Acute Stage
- ☐ Bleeding
- ☐ Cardiac Insufficiency
- ☐ Contagious Conditions
- ☐ Fever
- ☐ Intoxication
- ☐ Require continuous use of Oxygen
- ☐ Severe Kidney Disease
- ☐ Severe/Unstable Heart Disorders
- ☐ Spitting up Blood
- ☐ Stage 3 COPD
- ☐ Uncontrolled Blood Pressure

By initialing below, I confirm that **I DO NOT** have any of the above symptoms at present time:

Initial Here: _____

I, the above named client, have requested and agreed to undergo the process of Salt Therapy, aka Halotherapy and/or Infrared Therapy. I have been informed about the potential benefits, risks, and consequences of Salt Therapy/Infrared Therapy. All my questions pertaining to this therapy have been answered to my satisfaction. I am satisfied with and understand the information provided as well as I acknowledge that LKN Salt Spa recommends that all medical conditions should be treated by a physician competent in treating that particular conditions. I further acknowledge that LKN Salt Spa takes no responsibility for clients choosing to treat themselves by means of this therapy, which is not intended to diagnose, treat, cure, or prevent any disease. I understand that for all my health concerns, it is my responsibility to consult an appropriately licensed healthcare practitioner and/or wellness physician. I further release LKN Salt Spa from any legal ramifications should an injury, death or illness occurs as a result of Salt Therapy/Infrared Therapy.

I hereby give my consent to participate in Salt Therapy/Infrared Therapy sessions entirely at my own risk.

Signature: _____ Date: _____

Smoking Policy

For the welfare of other salt therapy clients, we respectfully ask current smokers to refrain from smoking at least 2 hours prior to attending your salt therapy session. Third hand smoke can be dangerous for other clients with respiratory issues.

Are you a smoker? *(Circle)* Yes / No If yes, have you smoked in the last 2 hours? *(Circle)* Yes / No

*If you have smoked within the last 2 hours, we may reschedule your appointment for the same day if possible.

Initial Here: _____