



# Client Information & Disclosure Form

## Lake Norman Salt Spa

Client's Name (First, Last): \_\_\_\_\_

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)

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

# Consent & Release for Salt & Infrared Sauna Therapy

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

- |                                                              |                                                                       |
|--------------------------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> Active Tuberculosis                 | <input type="checkbox"/> Acute Inflammatory Disease                   |
| <input type="checkbox"/> Acute Stage of Respiratory Diseases | <input type="checkbox"/> Any Internal Disease in Acute Stage          |
| <input type="checkbox"/> Bleeding                            | <input type="checkbox"/> Cardiac Insufficiency                        |
| <input type="checkbox"/> Contagious Conditions               | <input type="checkbox"/> Fever                                        |
| <input type="checkbox"/> Intoxication                        | <input type="checkbox"/> Require continuous use of Oxygen             |
| <input type="checkbox"/> Severe Kidney Disease               | <input type="checkbox"/> Severe/Unstable Heart Disorders              |
| <input type="checkbox"/> Spitting up Blood                   | <input type="checkbox"/> Acute Joint Injury (IR)                      |
| <input type="checkbox"/> Stage 3 COPD                        | <input type="checkbox"/> Pace Maker/Defibrillator/Metal implants (IR) |
| <input type="checkbox"/> Uncontrolled Blood Pressure         | <input type="checkbox"/> Pregnant women/children (IR)                 |

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 Arden Salt Room & Sauna recommends that all medical conditions should be treated by a physician competent in treating that particular conditions. I further acknowledge the Arden Salt Room & Sauna 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 ARDEN SALT ROOM & SAUNA 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 \_\_\_\_\_