



# Client Information & Disclosure Form

**Lake Norman Salt Spa**

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)

<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 24 hours? (Circle) Yes / No

# 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:

- |  |  |
|--|--|
| <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"/> Stage 3 COPD                        |
| <input type="checkbox"/> 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: \_\_\_\_\_