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 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 _____