PERSONAL HISTORY INTAKE FORM AND DISCLAIMER

Name.....Phone..... Birthdate.....

Address.....City.....St.....Zip.....

Email.....

In case of emergency.....Phone.....

Referred by.....

General & Medical Information: Age..... Male Female Physician.....

Please carefully read the following information. A referral from your primary care provider may be required prior to service.

Circle Yes or No. If you answer yes to any of the following questions, please explain.

Yes No Have you ever experienced a salt cave before? How recently.....

Yes No Do you have any respiratory issues? Asthma, TB, Cystic Fibrosis, Allergies, Sinus

Yes No Do you experience frequent headaches?

Yes No Do you suffer from arthritis?

Yes No Do you have cardiac or circulatory disorders?

Yes No Do you have high blood pressure?

Yes No Are you currently sick? Cold, Flu etc?

Yes No Skin conditions: eczema, psoriasis, etc.?

Yes No Do you suffer from either hyper or hypo Thyroid? (Circle one)

Yes No Do you have any kidney issues?

Yes No Are you currently using any form of Chemotherapy? .....

You may experience a dry throat and increased coughing after your first session. This is a natural part of the clearing process of the respiratory system. The pollution which has accumulated over time is being released by the salt and is then expelled from within the deepest regions of the lungs. I understand that Salt Therapy Session should not be construed as a substitute for medical examination, diagnosis or treatment and that should I see a physician, or other qualified medical specialist for any mental or physical ailment of which I am aware. Salt Therapy should not be performed under certain medical conditions. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

NO ELECTRONICS ARE ALLOWED IN THE SALT CAVE!