



Breathe Well — Look Well
Feel Well

128 Sumner Road, Fayetteville, GA 30214 • 678-964-SALT



Welcome to Salt MedSpa!

We are **delighted** that you are here.
Please answer the questions below so that we may
take **excellent care** of you and your family.



Please Note: This a fragrance free establishment. Any perfumes,
smoke, or scents may cause a severe reaction in others.

Please fill out the form below.

Name: _____ Nickname?: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Email: _____

Preferred communication for confirming appointments and other special offers:

Phone _____ Email _____ Text _____ Cell #: _____

Emergency Contact: _____ Relationship: _____ Emergency Contact Phone: _____

Allergies: _____

Occupation: _____ Primary Care Physician: _____

Are you:

☐ Male ☐ Female ☐ A smoker

 (See Halotherapy Etiquette...)



Have you previously visited a salt room?

☐ Yes ☐ No



Please check any conditions you (or your child) experience:

- | | | |
|--|--|--|
| ☐ Acne | ☐ Hay Fever | ☐ Sore Throat |
| ☐ Asthma | ☐ Laryngitis | ☐ Stress |
| ☐ Bronchitis | ☐ Mood Swings | ☐ Stuffiness |
| ☐ Colds and Influenza | ☐ Neurodevelopment Disorders | ☐ Tonsillitis |
| ☐ COPD | ☐ Pneumonia | ☐ Trouble Sleeping |
| ☐ Cough | ☐ Psoriasis | ☐ Wheezing |
| ☐ Cystic Fibrosis | ☐ Recent Cosmetic Surgery | ☐ (other) _____ |
| ☐ Depression | ☐ Respiratory Infections | ☐ (other) _____ |
| ☐ Dermatitis/Eczema/Rashes | ☐ Runny Nose | ☐ (other) _____ |
| ☐ Ear Ringing | ☐ Seasonal Allergies | ☐ (other) _____ |
| ☐ Earache/Ear Infections | ☐ Shortness of Breath | ☐ (other) _____ |
| ☐ Emphysema | ☐ Sinusitis | ☐ (other) _____ |
| ☐ Fatigue | ☐ Snoring | ☐ (other) _____ |



**Halotherapy should not be undertaken if you are
currently experiencing the following:**

- | | | |
|------------------------------|-----------------------------------|---------------------------------------|
| • Active Tuberculosis | • Severe/Unstable Heart Disorders | • Uncontrolled blood pressure |
| • Fever | • Stage 3 COPD | • Severe Kidney Disease |
| • Acute Inflammatory Disease | • Intoxication | • Any Internal Disease In Acute Stage |
| • Contagious Conditions | • Spitting Up Blood | • Require Oxygen |

We are here to help you as much as we can.
If you have ANY questions, don't hesitate to ask.





Consent Form



Halotherapy is a 100% natural and drug-free treatment. It can be used as a complementary treatment to prescribed medications or as a stand alone therapy. When used as a complementary therapy, it may increase the effectiveness of prescribed medications and decrease the amount needed.

Although studies conducted outside of the USA do indicate that Halotherapy appears to have health benefits as an addition to more traditional forms of medicine, Salt MedSpa does not claim to be a replacement for medication or any medical treatment of any kind. Only your physician can best advise you on matters of your health. Research supporting the use of Halotherapy has not been evaluated by the FDA.

As a client of Salt MedSpa, LLC, I have requested Halotherapy. I understand the nature of Halotherapy, the potential benefits, risks, and consequences have been explained to me and all of my questions have been answered to my satisfaction.

I hereby acknowledge the unproven and unconventional nature of Halotherapy and have requested the therapy notwithstanding.

I am satisfied and understand the information provided as I acknowledge that Salt MedSpa, LLC takes no responsibility for clients choosing to treat themselves by means of Halotherapy, which has not been evaluated by the FDA, and is not intended to diagnose, treat, cure or prevent any disease.

I understand that for all my concerns, it is my responsibility to consult an appropriate licensed healthcare practitioner. I further release Salt MedSpa, LLC from any legal ramifications should injury, death, or illness occur as a result of Halotherapy.

I have read Salt MedSpa's Halotherapy Etiquette information and agree to adhere to these policies.

Dated this _____ day of _____, 20_____.

Signature of Client or Guardian

Signature of Witness

Printed name of Client or Guardian

Printed name of Witness

