ELLICOTTVILLE SALT CAVE

PERSONAL HISTORY INTAKE FORM AND DISCLAIMER

Name_____ Phone_____ Birthdate_____
Address_____ City_____ State_____ Zip_____
Email_____
In case of emergency_____ Phone_____
Referred by_____
Occupation_____ Age_____ Male____ Female____

Please carefully read the following information. A referral from your primary care provider may be required prior to service. Please circle Yes or No. If you answer yes to any of the following questions, please explain.

Have you ever experienced a salt cave before? YES NO
How recently_____ Where_____
Do you have any respiratory issues? YES NO
*Asthma, TB, Cystic Fibrosis, Allergies, Sinusitis, etc.*_____
*Are you pregnant? YES NO # of weeks:_____ Have you received a massage before? YES NO

Past Medical History

Please check for any of the following symptoms which you now have or have had. Please take your time. THIS IS A CONFIDENTIAL HEALTH REPORT.

___Abdominal Pain
___Allergies
___Anemia
___Arthritis
___Asthma
___Bursitis
___ Cancer
___Carpal Tunnel Syndrome
___Chemotherapy
___Circulatory Issues
___Congestive Heart Failure
___ Currently Sick
___Diabetes
___Dizziness/Fainting
___Fever
___Fibromyalgia
___Gout
___Headaches
___ Heart Attack/Disease
___Hernia
___High Blood Pressure
___Hypo/Hyper Thyroid
___ Insomnia
___Metal Pin/Rods/Artificial Joints
___Multiple Sclerosis Stress
___Neuropathy
___Pacemaker/Defibrillator
___Recent Surgery
___Sciatica
___Scoliosis
___Seizure
___Skin Conditions/Eczema/Psoriasis
___ Sprains/Strains
___Stroke/Aneurism
___Ulcer
___ Varicose Veins

Back Pain: ___Neck ___Mid Back ___Low Back ___Tail Bone

Are there any other medical conditions your therapist should be aware of?
_____
_____
_____

OVER =>

Salt Cave Clients:

Our cave is video monitored 24/7 for the purpose of securing the safety of all our guests during their visit. Please do no t touch the walls, water features, or other items in the cave unless otherwise advised. Children must be supervised at all times while in the cave. They are not allowed near the water feature. They may not climb on the walls. Thank you for upholding our policy!

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 I should see a physician or other qualified medical specialist for any 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.

Signature_____Date_____

Massage Clients:

Please read the following and sign below: I understand that massage is not a replacement for medical care and that no diagnosis will be made. We reserve the right to refuse or discontinue treatment according to medical conditions, non-compliance with ethical codes or sexual misconduct.
I attest that all of the above is true and to the best of my knowledge.

Signature_____Date_____

Sauna Clients:

Please be cautious and open the door of the sauna to allow cool air to come in if you are too hot. We will set your first session at a lower temperature.

I, the undersigned, consent to the Infrared Sauna Treatment. I understand that these procedures are for the purpose of detoxification and are not intended to take place of medical care or medications. I clearly confirm that I do not hace any contraindications to the Infrared Sauna Treatments. I understand that I can discontinue my treatments at anytime. I understand that I take full responsibility for my own health and well-being.
I have read the above disclaimer (including cautions and contraindications for the use of the Infrared Sauna).

Signature_____Date_____