INTEGRATED HEALTH CENTER
Salt Room Intake

PATIENT INFORMATION

Name_____ Date _____ Referred by_____

Address_____ City_____ State_____Zip_____

Date of Birth_____ Home Phone_____ Cell Phone_____

Email Address_____ Emergency Contact_____ Phone_____

Informed Consent

The above named client, have requested and agreed to undergo the process of Halotherapy. I have been informed of the potential benefits, risks, and consequences of Halotherapy, which is unconventional in nature and all my questions, have been answered to my satisfaction. I am satisfied with and understand the information provided as I acknowledge that Integrated Health Center takes no responsibility for customers choosing to treat themselves by means of Halotherapy, which has not been evaluated by the Food and Drug Administration and 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. I further release Integrated Health Center from any legal ramifications should injury, death, or illness occur as a result of Halotherapy.

I do not have any of the following conditions:

- Acute stage of respiratory' diseases
- Chronic obstructive lung diseases with 3~ stage of chronic lung insufficiency
- Intoxication
- Cardiac Insufficiency
- Bleeding
- Blood Spitting
- Hypertension in II B stage
- Any and all internal diseases in acute stage
- Kidney Disease (acute stage)

I herby give my consent to participate in the Halotherapy sessions entirely at my own risk.

Signature:_____ Date:_____

Current reason for Salt Spa use:_____

Past Medical History limited to respiratory' and skin health _____

Are you a smoker? ____yes ____no List any allergies:_____

Review of Symptoms Checklist (mark all that apply)

___Fatigue	___Headache	___Lumps	___Skin Dryness	___Skin color changes	___Chest pain
___Earache	___Stuffiness	___Discharge	___Sore Tongue	___Swollen glands	___Difficulty breathing
___Itching	___Drainage	___Fainting	___Tingling	___Sore tongue	___Hair/Nail changes
___Tremor	___Hives	___Skin Rash	___Allergies	___Painful breathing	___Decreased hearing
___Numbness	___Tightness	___Weakness	___Sore Throat	___Hay Fever	___Coughing up blood
___Dry Mouth	___Hoarseness	___Stress	___Wheezing	___Decreased hearing	___Ringing in ears
___Depression	___Edema	___Snoring	___Night Sweats	___Shortness of breath	___Trouble sleeping
___Palpitations	___Seizures	___Dizziness	___ Numbness	___Nervousness	