SALT COVE WELLNESS INTAKE FORM[1]

Print
Name_____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Email _____ Birthdate _____

For minors:

Guardian:
Sign_____Print_____Relationship_____

1. How did you hear about us:____Website___ Social Media __ Internet Search ___ Friend/ Family ___Doctor Referral __Advertisement __ Other_____

2. Are you currently under a doctor care for a specific problem?

_____

_____

3. What bring you to Salt Cove Wellness Today, what are we doing for you?
_____

4. Do you have allergies?_____

5. Have you experienced a salt room session before?
_____

6. Salt room sessions are not substitute for medical care, but is a compliment to most types of treatments. Understand that Salt Cove Wellness do not medicate, diagnose, or treat any disease, and in the event that you are feeling sick, we strongly recommend you to contact your doctor prior of initial services._____

7. I give consent to Salt Cove Wellness to provide me with the services I have requested, I acknowledge that I have read and understand the information above and below. _____

8. **I understand that my file and personal information are kept with the utmost respect, integrity, and confidentiality. I agree to hold Salt Cove Wellness free of any liability as a result of me not disclosing any allergies, medical conditions or not consulting my physician, if I happened to be under a doctor's care for any particular issues.**_____

Client Signature:_____ Date:_____
_____

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