Cupping Therapy - Consent and Release Form

About Cupping Therapy

Cupping is a therapeutic technique that comes from traditional Chinese medicine (TCM) and is believed to have numerous health benefits in addition to stimulating the flow of qi ("life force") within the body. This body treatment integrates well with massage therapy, and involves applying a localized negative pressure (suction) to the skin using glass, plastic or silicone cups at targeted areas of the body. The intent of this therapy is to stimulate the function of the circulatory and lymphatic systems. It may also help to release congested tissues and loosen adhesions at superficial tissues of the body.

Contraindications for Cupping Therapy

The following is a partial list of common conditions which are considered contraindications for cupping therapy:

- Blood clots
- Bleeding disorders
- Bruise easily
- Hemophilia
- Injured areas
- Infections
- Acute skin conditions
- Sunburn / rash
- Skin lesions
- Cancer
- Areas of herniation
- Hematomas
- Phlebitis / varicose veins
- Impaired sensation
- Edema / lymphedema
- Certain medications

Please Read and Initial Each Item Below

_____ Information about massage cupping in general, techniques, potential benefits, effects, risks, after-care recommendations, and possible alternative therapies have been explained to me and I understand this information.

_____ I understand that the vacuum formed by cupping may result in marks being left on my body.

_____ My therapist has informed me of the contraindications of cupping therapy, and I have provided my therapist with an accurate and complete medical history to rule out any contraindications to receiving this treatment.

_____ I agree to communicate to my therapist any physical discomfort experienced during the session.

_____ I have been given an opportunity to ask questions about cupping therapy and have had my questions answered to my satisfaction.

_____ I am not taking blood thinners, and I have no contraindications for cupping therapy.

_____ I release the massage therapist and business from all liability for any harm that may unintentionally result from this treatment.

I further understand that massage and cupping therapy is not a substitute for a medical examination or treatment, and that I should see a physician or other qualified health specialist for any mental or physical ailment of which I am aware. I understand that massage therapists do not diagnose illness or disease, and nothing said during the treatment should be construed as such. My consent is informed and voluntary and I understand that I may withdraw my consent at any time except for actions already taken.

By signing this form I agree with the statements above and give my consent to proceed with cupping therapy.

_____ _____/_____/_____

Client Name (Please Print) Date

_____

Client Signature