Beth Elliott Bodywork, LLC

NC LMBT #12701

Cupping Therapy Client Release Form

• I understand that Massage Cupping should not be combined with aggressive exfoliation, 4 hours after shaving or after sunburn.
• I understand that I should avoid exposure to cold, wet, and/or windy weather conditions, hot showers, baths, saunas, hot tubs, or aggressive exercise for 4-6 hours. I understand that exposure to such extremes can produce unnecessary strain on my body and I should avoid these activities until my body feels ready for normal activity.
• I understand that I need to drink water and avoid high sugar drinks, alcohol, and eat light meals to ensure my body has the time and energy to integrate the benefits of the work I received.
• It has been explained to me that there is the possibility of discolorations that can occur from the release and clearing of stagnation from my body.
• I also understand that this reaction is not bruising, but due to cellular debris and pathogenic factors being drawn to the surface to be cleared away by my circulatory and lymphatic system.
• I further understand that the discolorations will dissipate from a few hours to as long as 2 weeks, in some cases.
• To avoid any adverse reactions, I have fully disclosed all health factors to my therapist including any that may not be listed on the health intake form. I understand that cupping therapy is not appropriate for everyone so I will also inform my practitioner of any changes in my health.
• I understand the the first time I experience cupping, my body's immune system can temporarily react to this release in a similar way to having a mild flu or the common cold-producing flu/cold like effects like nausea, headache, aches, that will subside with rest, time, and water. Water helps to dilute the intensity of the release and facilitates the elimination of the aforementioned stagnation.
• Information has been provided to me about Cupping Therapy. If I choose to experience Massage Cupping during treatments, I understand the potential effects and after-care recommendations.

I agree to allow the Cupping Practitioner to preform Cupping, I also acknowledge that I have read, understand and will follow all the information stated above and will not hold the practitioner responsible for any adverse effects as a result of the treatments I received. In addition I understand it is my responsibility to communicate with my Cupping Practitioner if the pressure is too deep, too fast, or causes high pain or discomfort.

Signature of Client_____ Date_____