CUPPING CONSENT FORM

I understand that cupping therapy will leave bruise like marks that will last several days to several weeks depending on the severity of my condition. While most marks fade and disappear after a few days, there are times when marks could take up to 15 days to clear and in rare cases, it has been reported that marks have taken up to 21 days to fully clear. These areas of bruising or discoloration are typically not painful, but can on occasion have soreness, itching and there may be soreness in the surrounding muscles. Cupping therapy is a medical treatment, not a novelty and should be treated accordingly. Your therapist will determine which areas are most appropriate for cupping, which type of cupping methods should be used and where how many cups should be applied, the length of time the cups should remain on and which cupping techniques (stationary, moving, etc.) to employ. This is not a service in which the patient should expect to dictate the terms of the service such as in a massage service.

I understand that cupping treatments can be a "detoxifying" treatment process and as a result, I may feel nauseous or unwell following treatment. Drinking water and taking Vitamin C has been reported to relieve these symptoms quickly. In some cases, headaches and minor body aches may be experienced.

Contraindications:

- Hemophilia or other bleeding/clotting disorders
- Patients taking blood thinners
- Weak patients or those who have been ill.
- Abdomen on pregnant women
- Diabetics (Especially those with uncontrolled blood sugar as they may not be able to feel pain properly.)
- Those who are unable to experience pain properly
- Those who have circulatory conditions
- Those who are unsure if their condition is contraindicated should seek guidance from their primary care physician prior to receiving cupping therapy.

I _____, understand that bruising, discoloration and/or soreness will likely occur following this treatment and may take days or weeks to fully resolve. I further understand that the above listed conditions are contraindicated for cupping therapy and I have informed my therapist/physician of any and all medical conditions, even those not listed as contraindications.

_____ _____

Signature Date