CUPPING THERAPY CONSENT FORM

About Cupping:
Cupping is a therapy that applies negative pressure on the skin using glass, plastic, or silicone cups. The suction created by these cups stimulates and increases blood flow, which can help relieve joint and muscle pain, reduce inflammation, accelerate recovery, increase the function of the lymphatic and circulatory systems and increase overall relaxation and well-being. Cupping may also aid in the healing of scars and surrounding tissues.

There are cases where we **do not** do cupping, such as:

- Skin Lesions or Inflammation (already present)
- Organ Failure (Renal, Hepatic, and/or Cardiac)
- Pacemakers
- Hemophilia or similar bleeding disorders
- Cancer
- Varicose Veins, Spider Veins

Caution should be taken with any of the following conditions, please talk with your practitioner if you are experiencing any of these:

- Diabetes with complications or an acute infection
- Taking anticoagulant medication ex. Aspirin, warfarin etc.
- Severe chronic disease such as Heart Disease
- You are pregnant, are within 6 weeks after giving birth, or are menstruating
- Lymphedema or Anemia
- New Tattoos (localized)
- Recently given blood or undergone a medical procedure

❒ I understand that static cupping may result in marks being left on my body and these marks can take anywhere from a few hours to up to two weeks to dissipate. These can look like a bruise.

❒ I understand the cupping marks may or may not be tender to the touch and that I will inform my practitioner if I am uncomfortable at any time during my treatment.

❒ I understand that if I am receiving facial cupping (for cosmetic, TMJ issues, headaches, sinusitis, Bells Palsy, Trigeminal Neuralgia, etc) that in order to treat these conditions most effectively, cups may be left in one place for up to 2 minutes. Depending on my skin type I understand this type of treatment may leave cupping marks on my face.

❒ I understand and I am aware that there can be side effects to cupping such as nausea/vomiting, fainting, blisters/infections, bleeding, bruising, headaches, dizziness, fatigue, and others.

I, _____ (print full name) consent to allowing the Cupping Practitioner / Massage Therapist _____ to perform Cupping Therapy. I understand the benefits, side effects, contraindications, and the possibility of cupping marks as part of the massage and will not hold the Massage Therapist responsible. I have asked all necessary questions and have had any concerns addressed.

_____ _____

Signature of Client Date of treatment