CUPPING THERAPY CONSENT FORM

About Cupping:

Cupping is a therapy, which applies negative pressure on the skin using glass or silicone cups. The suction created 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 system and increase overall relaxation and wellbeing. By creating suction, negative pressure cupping lifts and releases congested connective tissue (by aligning the collagen fibers), loosens adhesions and helps re-oxygenate old tissues that have been injured while increasing healthy circulation to the targeted area. The benefits of cupping are numerous.

- I understand that the vacuum formed by cupping may result in marks being left on my body.
- I understand cupping marks can be considered bruises. These marks indicate congestion in local blood circulation and are an indication that local capillaries have been broken and metabolic waste removed.
- I understand these marks should dissipate within a few hours to as long as two weeks.
- I understand as cupping treatments continue, the discoloration of these marks will become less obvious.
- I understand cupping marks should not be tender to touch and no pain should be felt.
- I understand if I am receiving facial cupping (for cosmetic, TMJ, headaches, sinusitis, Bells Palsy, Trigeminal Neuralgia etc..) in order to treat these conditions most effectively cups may be retained in one place for up to 2 minutes. Depending on my skin type I understand my face may acquire cupping marks.
- I agree to inform my practitioner if I have the following conditions and to list any medications I am currently taking;
    - Deep Vein Thrombosis (blood clots)
    - AutoImmune Disease: ie. Lupus, MS, Parkinson's, Other:
    - Diabetes
    - Heart Disease
    - Lymphedema
    - Cancer
    - Injections/Patches: Botox, Steroid, Insulin, Birth Control, Nicotine, Other:
    - Chronic illness not mentioned above. Please list:
    - Medications currently taking. Please list:

I, _____(*print client's full name)* consent to allow the Cupping Practitioner ( ) to perform Cupping Therapy. I understand the benefits, side effects, contraindications and the possibility of cupping marks as part of Cupping Massage and will not hold the practitioner responsible.

_____ _____

Signature of Client **Date**