**Cupping Therapy- Consent and Release Form**

**About Cupping Therapy**

Cupping is therapeutic technique that is used in 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 treatments integrates well with massage therapy, and involves applying a localized negative pressure (suction) to the skin using glass, plastic or silicone cups at targeted area 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**

* 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
* Medications: Warfarin (Coumadin)

**Please Read and Initial Each Item Below**

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

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

\_\_\_\_ I agree to communicate to my Acupuncturist and physical discomfort experienced during the session.

\_\_\_\_ I have been given the 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 Acupuncturist 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 Acupuncturist and Massage therapist do not diagnose illness or disease, and nothing said during the treatment should be constructed as such. My Consent is informed and voluntary and I understand that I may withdraw my consent at any time except for when actions already taken.

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

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_