Cupping Therapy Client Release Form

Please read the following carefully and initial after each statement:

I am not taking blood thinners, experiencing a fever, in treatment for cancer, recovering from recent surgery, have hemophilia or bleeding/clotting disorders, diabetes, heart disease, have a contagious skin condition, nor am I currently pregnant. x_____

I understand that the first time I experience cupping, my body's immune system can temporarily react to the movement of fascia and circulation of blood in a similar way to having a mild flu, producing effects such as nausea, headaches, exhaustion, or soreness that will subside with rest, time and water. X_____

I understand that during the cupping session I will feel a light- strong suction in the areas I have chosen for treatment. I may experience temporary tingling or itching at the site of application due to increased vascularity of the area. X_____

I understand that there is the possibility of discolorations or bruise-like markings that can occur from the suction applied to the skin from the cups. I understand that this type of cupping therapy is used to relieve pain/tightness in the body, via myofascial movement/release, or blood/lymph stagnation in the body tissue. I further understand that the discolorations will dissipate anywhere from a few hours to as long as 2 weeks in some cases in relation to my after-care activities. x_____

I understand that cupping therapy should *not* be combined with aggressive exfoliation, shaving, sunburn or when I'm hungry or thirsty. I understand that I need to drink water and avoid excessive sugar, caffeine, alcohol, drugs, and eat light meals to ensure my body has the time and energy to integrate the benefits of the therapy I have received. x_____

I understand that I should avoid exposure to cold, wet, and/or windy weather conditions, hot showers, baths, saunas, hot tubs, and strenuous exercise for a minimum of 4-6 hours. I understand that exposure to such extremes can produce undesirable effects. x_____

I understand that it is my responsibility to communicate any physical discomfort to my therapist during the cupping session. x_____

I have read all of the disclaimers above. I understand that there are contraindications for cupping therapy. I have fully disclosed all health factors to my therapist, including those not mentioned in my intake form, to avoid any complications. Information has been provided to me about cupping therapy. If I choose to experience these therapies, I understand the potential effects and after-care recommendations. I have had the opportunity to ask any questions about this therapy. By signing below I agree to release Laura Graham L.M.B.T. from any liability in connection with receiving cupping therapy.

Client name printed:_____

Client signature: _____ Date:_____