Cupping Therapy Intake Form

Today's Date:___/___/____

Name:_____ DOB:____/____/_____

Phone #: _____ Email:_____

Emergency Contact:_____Emergency contact phone # :_____

Is this your first cupping session? YES / NO

When (approximately) was your last massage or cupping session?_____

What is your primary goal for today's session?_____

Please circle 1-3 areas where you would like to receive focused cupping massage:

Neck / Shoulders	Back	Hips / Glutes	Upper Legs
Arms	Chest (pectoralis)	Abdomen	Lower Legs

Please provide any specific complaints / information for the above areas you selected:

_____

_____

Please check any condition listed below that currently applies to you:

( ) Contagious skin condition
( ) Easy Bruising
( ) Sprains/Strains
( ) Decreased Sensation / Numbness
( ) Sensitive Skin (easily irritated)
( ) Thin Skin (tears easily)
( ) Broken Skin/ Open wounds
( ) Sunburn
( ) Varicose Veins
( ) Pregnancy
( ) Diabetes
( ) High/ Low Blood Pressure
( ) Joint disorder/ Rheumatoid Arthritis/ Osteoarthritis
( ) Deep vein Thrombosis/ Blood Clots
( ) Lymphatic Illness

( ) Cancer:
( ) Infection/ Cold/ Flu
( ) Hemophilia
( ) Joint Replacement
( ) Heart Condition
( ) Pacemaker
( ) Kidney Disorders/ Stones
( ) Asthma
( ) Lung conditions
( ) Vertigo
( ) Fever/ Chills
( ) Seasonal Allergies
( ) Hernia
( ) Recent Fracture/broken bone
( ) Other:_____

Please list any bodywork therapies you receive:_____
(massage, acupuncture, chiropractic etc.)

Do you have any allergies to topical oils/ lotions/ ointments/ essential oils/ nuts?

_____

Do you smoke ? ( ) No ( ) Yes ( ) Formerly

List *all* medications you are currently taking (e.g. blood thinners/ painkillers/ antibiotics, antidepressants etc.)

_____
_____
_____

List any major illnesses/ hospitalizations:

_____
_____
_____

List *all* surgeries (include year or age):

_____
_____
_____

Is there anything about your health history that you think would be useful for your therapist to know in order to plan a safe & effective session for you?

_____
_____

*By signing below, I understand that cupping is not a substitute for medical care. I agree to keep my massage therapist updated to any changes in my health or medications before receiving cupping therapy.

Client Name (printed):_____

*Client Signature: _____ Date: _____