

Cupping Therapy Client Release Form

Health Enhancement Therapies

205 County Road 119, St. Michael, MN 55376

612-716-6199

- I understand that all treatments at this facility are therapeutic in nature. I agree to communicate to the therapist any physical discomfort or draping issues during the session.
- Information has been provided to me about Cupping Therapy. If I choose to experience these therapies during treatments, I understand the potential effects and after-care recommendations.
- It has been explained to me that there are contraindications for Cupping Therapy. I have fully disclosed all health factors to my therapist, including those not mentioned on my Health History Intake Form, to avoid any complications.
- It has been explained to me that there is the possibility of discolorations that can occur from the release and clearing of stagnation and toxins from my body.
- I also understand that this reaction is not bruising, but cellular debris, pathogenic factors and toxins being drawn to the surface to be cleared away by my circulatory systems.
- I further understand that the discolorations will dissipate from a few hours to as long as two weeks, in some cases, and in relation to my after-care activities.
- I understand that Cupping Therapy modalities should not be combined with aggressive exfoliation, done within 4 hours of shaving, after a sunburn or when I'm hungry or thirsty.
- I understand that I should avoid exposure to cold, wet, and/or windy weather conditions, hot showers, baths, saunas, hot tubs and aggressive exercise for 24 hours. It has been explained to me that exposure to such extremes can produce undesirable effects and I should avoid such situations.
- I understand that I should avoid caffeine, alcohol, sugary foods and drinks, dairy and processed meats and I should consume an abundance of clean water.

I _____ agree to allow the Cupping Practitioner to perform Cupping.

I also agree that I have read, understand and will follow all of the information stated above and will not hold the practitioner responsible.

Date _____ Signature of Client _____

Print Name _____

Date _____ Signature of Practitioner _____

Print Name _____

Cupping therapy contraindications

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In order to avoid unnecessary medical incident,
cupping therapy should be *used cautiously* if these symptoms occur as follows.

Please inform your practitioner if any of the following apply to you:

- (1) Sufferers who are prone to bleeding, such as purpura haemorrhagica, leukemia, hemophilia, capillary fragility test positive, and so on.
- (2) The damaged site of dermatologic disease, contagious skin disease, serious skin allergies, and part fester.
- (3) The part of acute soft tissue injury.
- (4) Trauma, fractures, varicose veins, the projection of vessel surface, the site of fresh scarring.
- (5) Lower abdomen, lumbosacral area, breast and other points as well as Hegu, Sanyinjiao, Kunlun in pregnant women should not be cupped.
- (6) The site of five sensory organs and two lower orifices should not be cupped.
- (7) Extreme weakness and thinness, skin without flexibility and the part of hairiness should not be cupped.
- (8) The mental disorders, the period of phrenoplegia, manic unrest and tetanus, rabies and other convulsive diseases.
- (9) Malignant tumors.
- (10) Severe edema, moderate or severe heart disease, heart failure, cirrhosis, ascites of the liver.
- (11) Active tuberculosis sufferers, in particular the abdomen of sufferers
- (12) People who are drunk, hungry, agitated, overtired.

Date _____ Signature of Client _____

Print Name _____