CUPPING INFORMED CONSENT FORM

I understand that all treatments are therapeutic in nature and not a substitute for medical advice or treatment recommended by my medical practitioner.

I agree to communicate with 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, I understand the potential effects and aftercare 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. I understand cupping will not be used on any open skin including on a fresh tattoo, which may be still in the process of healing.

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. Due to cellular debris, pathogenic factors and toxins are drawn to the surface, in the form of this discoloration, to be cleared away by my circulatory and lymphatic systems.

I further understand that discolorations will dissipate from a few hours to as long as 6 weeks in some cases and in relation to my aftercare activities.

I understand that cupping can cause temporary local skin itching and tenderness. I understand this is considered a normal result.

I understand that Cupping Therapy should not be used if I have recently shaved the area being treated, on areas I have sunburn, or if I'm experiencing hunger or thirst. I understand I should not apply aggressive exfoliation to treated areas and avoid prolonged exposure to extreme cold, hot, wet, and/or windy conditions for 24 hours (examples: long hot showers, baths, saunas, hot tubs, aggressive exercise, sunbathing, exposing cup marks to windy conditions). I understand that exposure to such extremes can produce undesirable effects and I should avoid such situations.

For best results, I understand I should consume an abundance of clean water and follow a healthy diet.

I give explicit consent for Cupping Therapy treatment. I agree that I have read, understand, and will follow all of the information stated above. I release The Walnut Tree Massage Therapy & Wellness Inc., its practitioners, and staff from any liability past, present, or future relating to treatment received at this clinic.

Date:_____ Printed name:_____

Signature:_____