

Cupping Therapy Client Release Form

Jennifer Sanders, CMP

760-415-3569

- 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 due to cellular debris, pathogenic factors and toxins being drawn to the surface to be cleared away by my circulatory system.
- I further understand that the discolorations will dissipate from a few hours to as long as 2 weeks in some cases, and in relation to my after-care activities.
- I understand that the first time I experience Cupping, my body's immune system can temporarily react to this release as it might with the flu – producing flu-like effects like nausea, headache, aches that will subside in time with rest and water. Water helps to dilute the intensity of the release.
- I understand Cupping Therapy modalities should not be combined with aggressive exfoliation, 4 hours after shaving, after sunburn, or when 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 4 – 6 hours.
- I understand 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 **Jennifer Sanders, CMP**, to perform Cupping Therapy. I also agree that I have read, understand and will follow all of the information stated above and will not hold the practitioner responsible.

Signature of client _____ **Date** _____

Print Name: _____