CUPPING CONSENT FORM

Name	Date

HEALTH HISTORY

Please check all current / past conditions that apply:

☐ asthma	☐ high blood pressure	☐ epilepsy
☐ cardiac issues	☐ low blood pressure	☐ photo toxicity
☐ acute lung/respiratory issues	☐ active cancer (ask for an Oncology Intake form)	

Have you had cupping therapy services before?
☐ Yes ☐ No If yes, please explain any previous complications or problems with cupping therapy:

Are you receiving homeopathic treatments?
☐ Yes ☐ No

Are you pregnant or trying to become pregnant?	Are you breast feeding?
☐ Yes ☐ No	☐ Yes ☐ No

Do you have any allergies and/or skin sensitivities?
☐ Yes ☐ No

Are there any additional medical issues we should know about?
☐ Yes ☐ No If yes, please explain the medical issue:

If you have an issue you do not wish to state on this form, please discuss it with your therapist.

Please list any conditions or side effects you have and/or medications you are taking associated with these conditions:

IF YOU HAVE ANY OF THE ABOVE CONDITIONS, PLEASE PRESENT A PHYSICIAN'S WRITTEN CONSENT PERMITTING YOU TO RECEIVE CUPPING SERVICES.

TERMS & CONDITIONS

BY SIGNING BELOW, I AGREE THAT I HAVE READ AND UNDERSTAND THE FOLLOWING:

☐ Information has been provided to me about Cupping Therapy and Cupping Massage. If I choose to experience these therapies, I understand the potential effects and after-care recommendations.
☐ I understand that my practitioner will work with me regarding my comfort level during treatment, and that is my responsibility to give feedback about what I am feeling immediately and to the best of my ability.
☐ It has been explained to me that there are contraindications for cupping. I have fully disclosed all health factors to my therapist, including those not mentioned on my Health History Intake Form.
☐ It has been explained to me that there is a possibility of discolorations that can occur from the release and clearing of stagnation and toxins from my body.
☐ I understand that the reaction of discoloration is not bruising, but rather is due to cellular debris, pathogenic factors, stagnation, and toxins being drawn to the surface to be cleared away by my lymphatic and circulatory systems.
☐ I understand that discolorations will dissipate over time and may take anywhere from two hours to two weeks or longer. I recognize the importance of after-care activities in relation to this, and acknowledge that marks are a potential physiological effect of cupping.
☐ I understand that cupping should not be combined with aggressive exfoliation or done within four hours after shaving, while sunburned, or when I am hungry or thirsty.
☐ I understand that I should avoid exposure to extreme cold or hot. I recognize that I should avoid cold, wet, or windy weather conditions, as well as hot or cold baths/showers, saunas, hot tubs, and aggressive exercise for 24 hours.
☐ I understand that it is recommended I avoid caffeine, alcohol, sugary foods and drinks, dairy and processed meats, and I should consume an abundance of clean water, particularly for the 48 hours following receiving Cupping Therapy or Cupping Massage.

I have completed this Cupping Massage and Cupping Therapy Consent Form to the best of my knowledge. I understand that massage sessions with cupping therapy do not take the place of a physician's care. Any information exchanged during a massage session is confidential and is only used to provide the best massage care. If I am having or develop any complications during a message session with cupping, I will discuss them with my massage therapist. I agree to allow the massage therapist to perform cupping. I also agree that I have read, understand, and will follow all the information stated above and will not hold the practitioner or Elements Massage responsible for aftereffects of cupping.

I hereby voluntarily release Operator dba Elements Massage™, Elements Therapeutic Massage, LLC, the franchisor of the Elements Massage™ franchise system, its and their affiliates and their respective shareholders, members, principals, owners, officers, directors, employees, agents, representatives, successors, and assigns from all claims, costs, demands, expenses, and causes of action should my condition be aggravated at any time. By signing below, I agree that I have read the information above and have decided to receive massage sessions with cupping and cupping therapy at my own risk.

Name of Studio Operator: Hedrick Wellness Group, LLC dba Elements Massage of Richardson ("Operator")
Studio Address: 150 N Plano Rd, Suite 210, Richardson, TX 75081 ("Studio")

Signature	Print Name	Date	MT Initials