COPPER TREE RETREAT
MASSAGE • MEDSPA

Cupping Release Form

Cupping Contraindications

Cupping therapy is not suitable for everyone. There are risks associated with performing cupping therapies on individuals with the following conditions.

You must inform your massage therapist/practitioner if you have any of the following conditions which may make cupping contraindicated or may require your therapist/practitioner to alter the treatment.

- Bruises
- Pregnancy
- Diabetes
- Inflammatory skin conditions
- Open wounds, sores, or thinning of the skin
- Hypotension or Hypertension
- Cancer (with or without treatment)
- Varicose veins
- Under the influence of drugs or alcohol
- Blood Clot(s)
- Cardiovascular Disease
- Neuropathy
- Autoimmune condition (MS, Lupus, RA, etc.)
- Peripheral vascular disease
- Heat sensitivity
- Compromised immune system
- Edema or Lymphedema]
- Blood Thinning medications

Client's Release

I, _____, have read and understand the aforementioned conditions which make cupping therapies contraindicated. The massage therapist/practitioner has discussed this information with me and provided opportunity for any questions. I have disclosed any and all health risk factors.

Please check the following that applies to you.

- ❏ I understand the information contained in this form and confirm that I do not have any of the above conditions.
- ❏ My condition(s) of _____ are listed above and therefore make(s) cupping contraindicated. Given this knowledge I hereby give my full consent to receive cupping therapy and take full responsibility for any side effects or harm that may come from my receiving cupping therapy.

I understand that I will be receiving cupping as an adjunct form of healthcare only and that this therapy is not meant to replace appropriate medical care. I understand the risks of bruising and muscle soreness that may occur directly or indirectly from cupping treatment. I release the massage therapist/practitioner and business of any and all liability for any harm that may unintentionally occur during my treatment(s).

Signature_____ Date_____