SWEET RELIEF
MASSAGE & RECOVER

CUPPING THERAPY CLIENT RELEASE FORM

☐ 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 that 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 therapists, 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 the 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 2 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, 4 hours after 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.

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

If there is any information that you think I need to know to be able to give you the best possible treatment, please don't hesitate to tell me. It is you responsibility to let me know if you feel any pain or discomfort at any time All your questions are very much welcomed.

Sign: _____ Date: _____