AchesAway™
massage specialists

CLIENT INFORMATION - CUPPING THERAPY RELEASE FORM

Personal Information

Name: ____ Date: ______________ Date of Birth: _______________

Address: _____________________________________ City: ________________________ State ____ Zip ___________

Phone: _______________ Occupation: ___________________________ Email: _________________________________

How did you hear about us? *(online search, gift certificate, social media, name of referrer - so we can thank them, other?)*

____

Health History

Please list any conditions that you have or are being treated for:

___Allergy to Latex
___Uncontrolled blood pressure
___Controlled High Blood Pressure
___Skin Sensitivity
___Dizziness/Vertigo
___TMJ Dysfunction
___Arthritis
___Bunions
___Chronic Muscle Pain
___Acute Muscle Pain/Spasm
___Spinal Subluxation (chiropractic)
___Allergic to Perfumes
___Cancer
___Heart Disease
___Sinusitis
___Tinnitus (ringing in the ears)
___Migraines
___Tendonitis
___Neurological Disorder (specify)
___Fibromyalgia
___Anatomically Short Leg
___Fused Vertebrae (specify)
___Other (please specify) ____

List any musculoskeletal surgeries and severe injuries you have had: ____

List any other surgeries and severe injuries you have had: ____

List all medications you are currently taking and what you are taking them for: ___________________________________

____

Cupping Contraindications

Please indicate Yes / No if any items apply to you:

Are you taking blood thinners? Yes / No
Do you have recent wound(s) from an operation or surgery? Yes / No
Have you had any lymph nodes removed? Yes / No
Do you have hemophilia or other bleeding/clotting disorder(s)? Yes / No
Have you had a recent joint injury (past 48 hours) that is still hot and swollen? Yes / No
Do you have a pacemaker or other implant(s) that could be affected by magnets? Yes / No
Do you currently have a fever? Yes / No
Are you pregnant? Yes / No

***Those who are unsure if their condition is contraindicated should seek guidance from their primary care physician prior to receiving cupping therapy.**

Why are you here for cupping therapy today?

___Just to relax
___Referral from a friend
___Injury Prevention (increase range of motion, joint mobility)
___Chronic or Acute Pain/Spasms
___Doctor or Chiropractic Referral
___Other? ____________________

What areas of your body need specific attention? ____

What did you like or dislike about previous massages? ____

Are you comfortable letting your therapist know if you have concerns about pressure, temperature or anything else during your session? ____

Do you have any specific requests for our session? (ex. Music, temp, etc.) ___________________

Please take a moment to carefully read the following information and sign where indicated:

Massage Cupping is a treatment of creating a vacuum suction in a cup, which is applied to the surface of the skin. The purpose of this technique is to promote health and healing by loosening soft tissue and connective tissue and increasing lymphatic flow and circulation. The cups are moved over the skin using gliding, shaking, popping and rotating techniques while gently pulling up on the cup, or may be parked or placed for a short time to facilitate joint mobilization or soft tissue release. Another benefit is to pull toxins and inflammation from the body to the surface of the skin where the lymphatic system can more readily eliminate them. The Bio-magnetic Blanket technique involves the placement of cups with magnets over the treatment area for approximately 15-20 minutes.

Potential reactions:

- *Cupping marks: discoloration due to metabolic waste, toxins and other stagnant material that have been freed from the underlying tissue can take up to 2 weeks to dissipate.*
- *Post treatment tenderness: Usually less than experienced from deep tissue work.*
- *Redness and itching: Increased vaso-dilation and/or inflammation brought to the surface.*
- *Very rarely a slight burn or blister may appear due to the heat and/or suction.*

Aftercare recommendations:

- ***Drink plenty of water to help eliminate toxins from the body.***
- *Avoid exposure to cold, wet and/or windy weather conditions, hot showers, baths, saunas, hot tubs and aggressive exercise for 4-6 hours.*
- *Light stretching and range of motion exercises are beneficial.*
- *Light exercise the next day will help increase circulation to aid in fading of cup kisses.*

If you are using the Infrared Sauna or Float at Aches Away on the same day of your cupping appointment, we recommend using those services <u>BEFORE</u> your cupping session.

Massage/bodywork is not a substitute for medical examinations, diagnosis, or treatments. I should see a physician for any physical or mental ailment. Massage therapists are not qualified to diagnose, prescribe, or treat any physical or mental illness, and nothing said in the session(s) should be construed as such. I have stated all known medical conditions and I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

Aches Away may request credit card information to hold appointments in situations where clients have missed appointments and do not call to cancel before 24 hours.

Signed: ____