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 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 clear 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 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 that Cupping Therapy modalities should not be combined with aggressive exfoliation, 4 hrs after shaving, after 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 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 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.

Date______________ Signature of Client ______________________________

Print Name ______________________________

Date______________ Signature of Practitioner ______________________________

Print Name ______________________________

ICTA Confidential Health History & Informed Consent Form

Confidential Health History:

Date: ______________

Name: ____

Address: ____

Phone: ________________ E-mail: ______________________

Date of Birth: ____________ Height: ______ Weight: ______

Occupation: ______________________ Referred by: ______________

1. What is your objective for undergoing Facial Cupping today?

   ____

2. Do you have any allergies or skin sensitivities? If so, to what products or compounds?

   ____

3. Would you consider your skin to be dry, normal, sensitive, combination, and /or oily?

   ____

4. Are you currently under the care of a dermatologist, or any medical doctor? If so, for which medical conditions?

   ____

5. Do you suffer from any skin conditions or other medical conditions? If so, what?

   ____

6. Are you currently taking any medications, vitamins, and / or supplements? If so, which ones?

   ____

7. By whom have these medications, vitamins, and /or supplements been prescribed, if anyone?

   ____

8. Do you wear contact lenses? Yes ______ No ______
9. Do you wear dentures or removable bridgework / retainers? Yes ______ No ______
10. Do you suffer from any of the following conditions? (Please **circle**):
    - Dark under eye circles
    - "Bags" under the eyes
    - "Creping" skin
    - Facial puffiness
    - Jowls

- Swelling secondary to mesotherapy treatments
- Eye strain
- Headaches
- Sinus congestion, pressure, and pain
- Blotchy skin
- Paleness, pallor, and / or a "washed out" complexion
- Combination skin (an uneven pattern of oily & dry skin)
- Temporalmandibular Joint (TMJ) Disorder

    ➢ TMJ disorder is the dysfunction of the jaw joint, its muscular, or both (manifesting as arthritis, inflammation, and / or dislocation of the TMJ).

- Spider veins / broken capillaries
- Wrinkles ("crow's feet," "parenthesis" around the mouth, "elevens" between the eyebrows)
- Scars & Adhesions
- Postoperative scar formation (after facial surgeries including face lifts or other surgical cosmetic procedures)
- Some earaches
- Sagging skin
- Facial pain
- Nerve impairment caused by pressure, inflammation or edema
- Chronic dry mouth
- Swelling & puffiness secondary to Mesotherapy treatments

(Contraindications):

- Any open sores or infections, including the broken skin associated with pimples or acne breakouts (Acne is actually a bacterial infection of the sebaceous glands.)
- Rosacea

    ➢ Rosacea is a chronic form of acne which can be triggered by sun, wind, cold, alcohol consumption, the ingestion of spicy foods, menopause, steroidal anti-inflammatory drug use, and stress. Rosacea normally manifests on the face, specifically the cheeks and the tip of the nose, and is characterized by persistent redness and swelling.

- Abcesses, pustules, blisters, or boils

- Any burn (including sunburn), blisters, or peeling skin
- Myasthenia gravis
  - ➢ This is an autoimmune disorder wherein the muscle cells at the neuromuscular junctions are threatened by the body's own immune system. This cell deterioration results in muscle weakness and chronic fatigability, especially in the throat and face.
- Mumps
  - ➢ This in an acute viral infection which is caused by a Paramyxovirus (an airborne member of the herpes family). Mumps causes the face to swell due to its effect on the salivary and parotid glands.
- Recent botulinum toxin injections (Botox) If so, how recently did you undergo the injections?____________________

Informed Consent:

If I experience any pain or discomfort during this session, I will immediately inform the Practitioner so that the amount of suction being administered can be adjusted to my level of comfort.

I further understand that Facial Cupping should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician or other qualified medical specialist for any physical conditions or medical concerns.

Because Facial Cupping should not be performed when certain medical conditions are present, I affirm that I have stated all my known medical conditions and answered all of the questions herein honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

Client Signature: ____

Date:______________

Practitioner's Signature: __________________________________

Date: ______________