PMB PROACTIVE MASSAGE+BODYWORK

Cupping Therapy Consent and Release Form

Cupping is a therapy that applies negative pressure to the skin using glass or silicone cups. The suction created stimulates and increases blood flow, which can help relieve joint and muscle pain, reduce inflammation, accelerate recovery, increase the function of the lymphatic and circulatory systems, and increase overall relaxation and well-being. By creating suction, negative pressure cupping lifts and releases congested connective tissue (by aligning the collagen fibers), loosens adhesions, and helps re-oxygenate old tissues that have been injured while increasing healthy circulation to the targeted area. The benefits of cupping are numerous.

Please read and initial on each line

_____I understand that the vacuum formed by cupping may result in marks being left on my body.
_____I understand cupping marks are not bruises. These marks indicate congestion in local blood circulation. And are an indication that local capillaries have been broken and metabolic waste removed.
_____I understand that these marks should fade within a few hours to two weeks.
_____I understand that as cupping treatments continue, the discoloration of these marks will be less obvious.
_____I understand cupping marks should not be tender to the touch, and no pain should be felt.
_____I understand if I am receiving facial cupping for TMJ, headaches, Sinusitis, Bell's Palsy, Trigeminal Neuralgia, etc., in order to treat these conditions most effectively, cups may be retained in one place. Although this is not the standard, as we try not to leave cups stationary on the face, depending on my condition and skin type, my face may acquire cupping marks.
_____I agree to inform my practitioner if I have the following precautions or conditions and to list any medication I am currently taking:

- ☐ Deep Vein Thrombosis (blood clots)
- ☐ Autoimmune Diseases: i.e. Lupus, MS, Parkinson's, etc.
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Lymphedema
- ☐ Cancer
- ☐ Taking Blood Thinners
- ☐ Injections/Patches: Botox, Steroids, Insulin, Birth Control, Nicotine, Etc.
- ☐ Chronic Illness Not mentioned above (Please List): _____
- ☐ Medications currently taking (Please List): _____

I, _____(Name of Client), consent to allowing the Cupping Practitioner, _____ (Name of Therapist), to perform Cupping Therapy. I understand the benefits, side effects, contraindications, and possibility of Cupping marks as part of Cupping Massage and will not hold the practitioner responsible.

_____ _____

Signature of Client **Date**

Note: We cannot evaluate your medical conditions, medications, allergies, or surgeries with regards to the safety of Cupping Therapy. If you have any questions about the status of your health, please consult your physician before engaging in any service.

This form accompanies the Massage Therapy Intake and Consent Form

Proactive Massage & Bodywork, LLC | NPI #1952948481
9225 Atlee Road | Suite 5103 | Mechanicsville, VA 23116
Phone: 804-559-7990 | info@proactiverva.com