Cupping Consent Form

1. Actively drink water to recover from marks, before and after.
2. Cupping is not encouraged while actively shooting photography/videography projects

Contraindications for Cupping

Yes / No	Organ Failure
Yes / No	Pacemaker
Yes / No	Hemophilia, Leukemia / Vasculitis / Thrombocytopenia
Yes / No	Cancer / Cancer therapy
Yes / No	Hernia
Yes / No	Psoriasis, Eczema, Rosacea, Hives, Herpes, Shingles
Yes / No	Sunburn, Rash, Pimples, Swelling
Yes / No	Fever, cramps, chemotherapy
Yes / No	Spider Veins, large superficial blood vessels, varicose veins
Yes / No	Geriatrics patients
Yes / No	Pregnant
Yes / No	Menstruating
Yes / No	High Cholesterol
Yes / No	Poor Circulation or Severe Heart Disease
Yes / No	Deep Vein Thrombosis
Yes / No	Open Wounds
Yes / No	Hypertension / High Blood Pressure
Yes / No	Bleeding Disorders (Anticoagulant Meds / Blood Thinner Meds)
Yes / No	Diabetic
Yes / No	Unhealed fracture or instability

I, _____ confirm that the cupping therapy practitioner Fusion Arts Physical Therapy has fully explained to me the benefits, side effects and contraindication of cupping therapy. I understand some degree of skin marking and bruising may occur from the cupping site which may last for 5 days or more.

Patient Signature _____ Date _____

Parent / Guardian _____ Date _____