# 1 Client Intake Form - CUPPING

**Member Information**

| | |
|---|---|
| **Member Full Name:** (Please print) | **Date of Birth/Age:** **Cell Phone Number:**<br>**____ /___ / _____** **_____** |
| **Full Mailing Address:** | **Email:** |
| **Is this your first cupping session? _____ Yes _____No**<br>**What is your primary goal for today's session?** _____<br>_____ | |
| **List any conventional /unconventional** medications, herbs, & therapies that you are currently trying/using. | |

**Medical Information**

Please mark **"C"** next to current or chronic issues and mark **"P"** next to those you have had in the past.

| | | | | |
|---|---|---|---|---|
| Broken Bone | Surgical Incision | Organ Failure | Insulin Monitor | Cancer |
| Varicose Veins | Pregnancy | Skin Disease | Appendix | Hernia |
| Dislocation | Hemophilia | Hearing Aid | Slipped Disc | Fever |
| Diabetes | Blood Thinner | Sunburn | Kidney Illness | Blood Pressure |
| Ulcerated Skin | Cardiopathy | Pacemaker | Joint or Bone Replacement | |

**List any major illnesses:** (What age?)

**List any major broken bones** (What age?)

**List any surgeries** (What age?)

**List any major hospitalizations** (What age?)

**Check today all that apply. ___ Fever ___ Infection ___ Cold/Flu ___ Inflammation ____ Pregnant/trying.**

***I understand*** *that all treatments at this facility are therapeutic in nature.* ***I agree*** *to communicate to my therapist any physical discomfort during the session. Information has been provided to me about massage cupping techniques.* ***If I choose*** *to experience these therapies during treatments,* ***I understand*** *the potential effects and after-care recommendations****. It has been explained to me*** *the possibility of discolorations that can occur from the release and clearing of stagnation and toxins.* ***I also understand*** *that this reaction is not bruising. I further understand that the discolorations will dissipate within a few hours to a week in some cases, and in relation to my after-care activities.* ***I understand*** *that cupping modalities should not be combined with*

*aggressive exfoliation.* ***I understand*** *that I should avoid hot showers, baths, saunas, hot tubs, and aggressive exercise for 24 hours.* ***I also understand*** *that I should avoid excess caffeine and alcohol and that I should consume plenty of clean drinking water.* ***See page 2 for signature(s) consent(s).***

**Consent to Treatment:** I hereby authorize the therapist to administer massage, cupping, bodywork, or facial treatments and any other requested services to myself as they deem necessary.

| | |
|---|---|
| **CLIENT (Self): (PRINT NAME)** | |
| **SIGNATURE:** | **Date:** |

**Consent to Treatment:** I hereby authorize the therapist to administer massage, cupping, bodywork, or facial treatments and other requested services to my child or dependent as they deem necessary. **I understand that anyone under the age of 18 that the parent/guardian must stay in the room during the complete session.**

| | |
|---|---|
| **Parent/Guardian: (PRINT NAME)** | |
| **SIGNATURE:** | **Date:** |

**Therapist's Signature:** _____ **Date:** _____

**NOTES:**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____