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Cupping Release Form

- I understand what is involved with Cupping and that there can be a “Cup-Mark” that will last several days to several weeks.
- I understand Cupping can be detoxifying and I may feel nauseous or unwell following treatment.
- I have disclosed any injuries, diseases, illnesses, conditions, or medications that would prevent me from receiving Cupping. Such as:
 - Diabetes with uncontrolled blood sugar
 - Neuropathy
 - Sunburn
 - Taking Blood Thinners
 - Hemophilia
 - Any Circulatory Conditions

I _____, understand that bruising/discoloration and/or soreness will likely occur following this treatment and may last for several days to a couple of weeks. I further understand that the above-listed conditions are contraindicated for cupping therapy and I have informed my therapist of any and all medical conditions, even those not listed as contraindications.

Signature: _____ Date: _____