EVERWELL
PHYSICAL THERAPY

Cupping Consent Form

Name: _____ **Date of Birth:** _____

Consent for Cupping Therapy:

I, the undersigned, hereby consent to the administration of Cupping Therapy by Everwell PT during the current visit and any subsequent visits as deemed necessary by my physical therapist.

Understanding Cupping Therapy:

Cupping Therapy is an ancient therapeutic technique that involves placing cups on the skin to create suction. This method increases blood flow, reduces muscle tension, and promotes healing. It is commonly used to alleviate pain, reduce inflammation, and enhance overall well-being. The suction created by the cups can also facilitate the removal of toxins and improve lymphatic drainage.

Potential Risks and Side Effects:

While Cupping Therapy is generally considered safe, it is important to be aware of potential risks and side effects, which may include:

- **Skin Discoloration:** Temporary marks resembling bruises may appear on the skin where the cups were applied; these typically resolve within a few days to two weeks.
- **Soreness:** Mild discomfort or tenderness in the treated areas, usually subsiding shortly after the session.
- **Burns or Skin Infections:** Rare occurrences, often due to improper technique or unsterilized equipment.
- **Dizziness or Nausea:** Some individuals may experience lightheadedness or nausea during or after treatment.

Contraindications:

Cupping Therapy may not be suitable for individuals with certain conditions, including but not limited to:

- Skin lesions or inflammation
- Organ failure (renal, hepatic, and/or cardiac)
- Bleeding disorders such as hemophilia
- Varicose veins or spider veins
- Severe chronic diseases such as heart disease
- Pregnancy, recent childbirth, or menstruation
- Lymphedema or anemia
- Recent tattoos or medical procedures

I acknowledge that I have read and understood the above information regarding Cupping Therapy, including its purpose, potential risks, and contraindications. I have had the opportunity to ask questions and have received satisfactory answers. By signing below, I consent to the treatment of Cupping Therapy by Everwell PT as part of my treatment plan.

Patient Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

**Note: This consent form will be maintained as part of your confidential medical record.*