

Karen Craven Acupuncture

Cupping Patient Intake Form

Thank you for coming. Please review, complete, and sign the form below prior to your cupping treatment. All your information will be confidential. If you have questions, please ask.

Cupping is a technique used to increase circulation, improve lymphatic drainage and reduce fluid build-up. Improved circulation can facilitate elimination of cellular waste and ease pain. Improved lymphatic drainage relieves the body of waste material. Reduced fluid and swelling in tissues can ease pain.

During cupping, I will place a glass cup on the skin after having removed the air from the cup. This will cause the skin under the cup to be gently suctioned into the cup. I can see how much suction I have applied and can adjust it by releasing some of the vacuum with my hand. The cup will stay in place from 5 to 10 minutes. Sometimes I may glide the cup over your skin after I have applied an oil. This gliding cupping feels like a deep tissue massage but with the tissue drawn up instead of pressed down and most patients love the sensation. Overall, patients describe cupping as a very pleasant experience.

If you have stagnate blood in the area where the cup is placed, you will mark a red to purple color depending on how bad the stagnation is. If you do not have stagnation, the cup will not leave a mark. The cupping marks are the shape of the cup, a circle, and usually disappear in 4 to 7 days. Cupping is safe, but will not be performed on individuals with bleeding disorders, varicose veins (on the vein), skin that isn't intact, heart or liver failure and the low back and abdomen of pregnant women..

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|---|----------------------------|----------------------------|--|
| Date | | | |
| Full name | | | |
| Date of birth | | | |
| Sex | <input type="checkbox"/> F | <input type="checkbox"/> M | |
| Address | | | |
| Street | | | |
| City | State | Zip Code | |
| Country | | | |
| Please check preferred contact method | | | |
| <input type="checkbox"/> Home phone # | | | |
| <input type="checkbox"/> Cell phone # | | | |
| <input type="checkbox"/> Work phone # | | | |
| <input type="checkbox"/> E-mail address | | | |
| Emergency contact information | | | |
| Contact name | | | |
| Contact phone # | Relationship to patient | | |

I understand the above information and confirm this form was completed correctly to the best of my knowledge.

Signature: _____ ☐ Adult patient ☐ Parent or Guardian ☐ Spouse