BALLARD CHIROPRACTIC CLINIC

9015 HOLMAN RD NW STE 3 ● SEATTLE, WA 98117 ● (206) 782-8500 ● ERIC R. WECHSELBERGER, DC

CUPPING THERAPY

Client Release Form

- I understand that all treatment at this facility are therapeutic in nature. I agree to communicate to the therapist any physical discomforts or draping issues during the session.
- Information has been provided to me about Cupping Therapy. If I choose to experience these therapies during treatments, I understand the potential effects and after-care recommendations.
- It has been explained to me that there are contraindications for Cupping Therapy. I have fully disclosed all health factors to my therapist, including those not mentioned on my Health History Intake Form, to avoid any complications.
- It has been explained to me that there is the possibility of discoloration that can occur from the release and clearing of stagnation and toxins from my body.
- I also understand that this reaction is not bruising, but due to cellular debris, pathogenic factors and toxins being drawn to the surface to be cleared away by my circulatory system.
- I further understand that the discoloration will dissipate from a few hours to as long as 2 weeks in some cases and in relation to my after-care activities.
- I understand that Cupping Therapy modalities should not be combined with aggressive exfoliation.
- I understand that I should avoid exposure to cold, wet and/or windy weather conditions, hot showers, baths, saunas, hot tubs and aggressive exercise for 24 hours. It has been explained to me that exposure to such extremes can produce undesirable effects and I should avoid such conditions.
- I understand that I should avoid caffeine, alcohol, sugary foods and drinks, dairy and processed meats and I should consume an abundance of clean water.

I _____ agree to allow the practitioner to perform Cupping Therapy. I also agree that I have read, understand and will follow all of the information stated above.

Date _____ Signature of Client _____

Print Name _____

Date _____ Signature of Provider _____

Print Name _____