Chinese Cupping Intake Form

Name_____Date_____/_____/_____

Address _____City _____ State___Zip Code _____

Phone# (day) _____(evening)_____

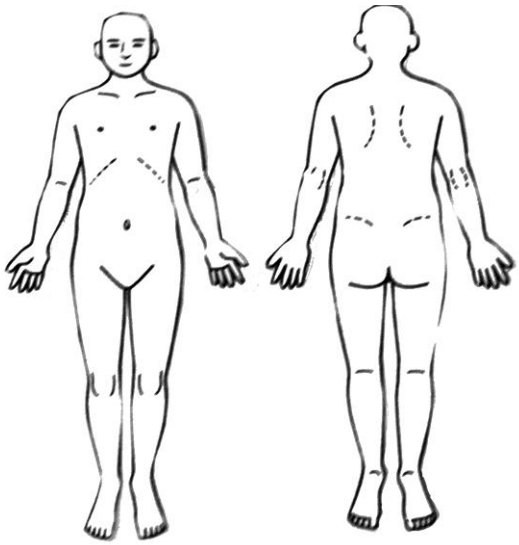
Email Address _____Referred by_____

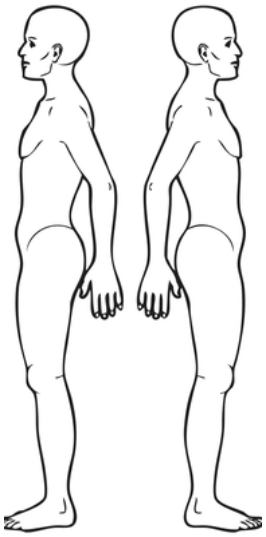
Date of Birth:___/ __ / ___ Age: __ Gender/Pronoun: _____Occupation:_____

Please complete this questionnaire as thoroughly as possible. All of your answers will be held confidential within lawful limits. If you have anything you wish to bring to our attention, which is not asked on this form, please note it in the 'Comments' section. Print all information and indicate areas of confusion with a question mark. Thank you.

Have you received cupping before? Yes No

Please **CIRCLE** locations on the diagrams where you are feeling any pain/tension/discomfort.





Check if you have:

___any bleeding disorders

___bruise easily

___are receiving chemotherapy or radiation

___have had a recent whiplash injury

___are taking blood thinning medications

___have active herpes or shingles

___are pregnant

Additional comments on anything above: _____

_____

Chinese Cupping-Financial Policy and Consent Form

Fee Structure:

Cupping $30–$60 per session.

Cancellation Policy:

A minimum of 24 hours advance notice is requested for a change or cancellation of appointment.

____A cupping appointment that is missed, rescheduled or cancelled with less than 24-hour advance notice will be **charged** $30 per missed cupping session.

There will be a $15 fee for any returned checks.

Consent:

____I understand that the cupping given here is for the purpose of stress reduction, relief from muscular tension, or for increasing circulation and energy flow. If I experience any pain or discomfort during this session, I will immediately inform the practitioner. I confirm that I was given a chance to review the explanation of cupping therapy including its side effects, and that the cupping therapy practitioner has explained the possibility of cupping marks.

____I further understand that cupping should not be construed as a substitute for medical examination, diagnosis, or treatment and that I am responsible for seeking out the care of a physician, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that cupping practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because cupping should not be received while experiencing certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

PLEASE INDICATE THAT YOU HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL POLICY AND GIVE YOUR CONSENT FOR TREATMENT AS STATED ABOVE BY SIGNING BELOW:

SIGNATURE: _____DATE:_____

PRINTED NAME: _____