POINT TO POINT
MOBILE PHYSICAL THERAPY

CUPPING CONSENT FORM

Consent for Cupping Therapy

I voluntarily consent to receive cupping therapy as part of my physical therapy plan of care. Cupping therapy is a manual therapy intervention that utilizes negative pressure (decompression) applied to the skin and underlying soft tissues with the goal of reducing myofascial restrictions, improving tissue mobility, decreasing pain, and facilitating functional movement.

The procedure, anticipated benefits, potential risks, and available alternatives have been explained to me, and I have had the opportunity to ask questions before consenting to treatment.

Potential Risks and Side Effects

I understand that cupping therapy is generally well tolerated; however, potential risks and side effects may include temporary discomfort during treatment, skin redness, circular discoloration (ecchymosis), petechiae, bruising, tenderness, swelling, lightheadedness, and, in rare instances, blistering, skin irritation, or infection. I understand that the circular marks commonly associated with cupping therapy are an expected response to treatment and may persist for several days to two weeks.

Contraindications and Precautions

I have informed my physical therapist of all relevant medical conditions, including but not limited to bleeding disorders, anticoagulant use, impaired sensation, compromised skin integrity, active infection, pregnancy, vascular disorders, or any other condition that may affect the safety of treatment. I understand that my therapist may modify or withhold cupping therapy if it is determined to be clinically inappropriate or contraindicated.

Voluntary Participation

I understand that participation in cupping therapy is voluntary and that I may decline or withdraw my consent at any time without affecting my access to other physical therapy services.

Acknowledgment and Authorization

By signing below, I acknowledge that I have read and understand this informed consent, my questions have been answered to my satisfaction, I understand the anticipated benefits, potential risks, and alternatives to cupping therapy, and that I voluntarily authorize my physical therapist to perform cupping therapy when clinically indicated as part of my treatment plan.

I, _____, authorize my evaluation and treatment by Point to Point.

_____ _____

Patient or Authorized Representative (Print / Signature) Date

_____ _____

Joshua Stallings, DPT Date

☐ I was offered a copy of this consent and refused.