# Zen Penguin Wellness Cupping Survey and Consent Form

Name _____ Date _____
Address _____
Cell Phone _____ Email _____

1. Have you ever received cupping before? Yes No
2. Please check any of the following you currently have (of have had) in the past year:
   □ Neck Pain □ Insomnia □ Headaches □ Back Pain
   □ Arm / elbow pain □ Muscle Spasms □ High Blood Pressure □ Depression
   □ Fatigue □ Anxiety □ Leg / knee pain □ Arthritis

3. These problems affect my:
   □ Home life □ Patience □ Energy □ Work life
   □ Family □ Attitude □ Activities □ Sleep
4. Would you like to know if acupuncture can help you get well and stay healthy? Yes No

## Informed Consent to Cupping Treatment

It is important that each client understand the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

I understand that the placement of glass cups can cause a specific stimulation of acupressure points. The specific acupressure points chosen elicit a calming and sedating effect, releasing endorphins that lead to reduced stress. After treatment it is normal to feel calm, relaxed and grounded. I understand that sometimes patients may feel slightly dizzy or disoriented, this is normal and should not last very long.

I understand that multiple cups may be used and placed at the same time. There may be some mild aches in the beginning of the procedure, but they should dissipate as the session continues. I have been informed that cupping is generally safe, but that it may have some side effects including bruising.

I understand that this treatment is **NOT** intended to diagnose or treat **ANY** disease or condition other than to perform a cupping treatment.

By signing the statement below, I hereby request and consent to the performance of the aforementioned cupping treatment(s), and in **NO WAY** hold the acupuncturist named on this document and/or the named clinic, responsible for **ANY** adverse reactions or exacerbations of **ANY** health conditions or side effects.

I, _____, have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept the acupuncture stress buster treatment on this basis.

Your credit card will NOT be charged unless you do not show for your scheduled appointment. If that occurs, a $30 fee will be charged to the card provided. Your card is only needed to guarantee your appointment.

_____
(Printed Name)

_____ _____
(Signature) (Date)

Credit Card: _____

Expiration Date: _____ CVV: _____

Please check the box below if you want to learn more about how acupuncture may be able to help you
□ I want to schedule an initial visit / acupuncture treatment within the next 2 weeks