MEDICAL HISTORY FOR HIJAMA THERAPY

NAME: _____ DOB: _____

1) Do you have any of the following:

□ Infectious Disease	□ Bleeding Disorders	□ Diabetes
□ Dizziness	□ Fainting	□ Stroke
□ Allergies	□ Epilepsy	□ Cancer
□ HIV/ AIDS	□ Herpes	□ Hepatitis
□ High Blood Pressure	□ Low Blood Pressure	□ Mental Disorder
□ Heart Disease	□ Kidney Disease	□ Liver Disease

(2) Please list any other major health conditions (past and present):

_____

_____

_____

(3) Please list all current medications:

_____

_____

_____

(4) Please list any past surgeries and corresponding year(s) conducted:

_____

_____

_____

(5) Please list any known allergies:

_____

_____

_____

FOR FEMALES:

(6) Are you currently pregnant? □ YES □ NO

(7) Are you currently menstruating? □ YES □ NO

CONSENT FOR HIJAMA THERAPY

I understand that if I am pregnant, currently menstruating or have certain bleeding disorders, I may not be able to have hijama performed on myself.

I understand that the hijama procedure is generally very safe but may have certain side effects, some of which include (but not limited to):

- temporary redness, discoloration, and/or pain
- risk of excessive bleeding
- risk of infection
- temporary lightheadedness or dizziness

I understand that hijama/ cupping may not necessarily treat or cure all or some of my disease(s).

I am an adult over the age of 18 years old and can make decisions on my own.

I understand that my medical history and results will be kept confidential.

I understand that it is preferable to not consume any food for 2 hours before the hijama procedure. I should also avoid caffeine, sugary foods and drinks, and dairy products for at least 24 hours after the procedure and drink plenty of clean water.

I understand that I should avoid aggressive exercise and I should avoid exposure to extreme heat, cold, rainy or windy weather for 24 hours after the procedure.

I declare I will not resort to any legal action or claim any compensation in case of any sort of loss or damage. I also release the facility where hijama is conducted from any medical claims or liabilities.

I give complete consent and permission to the hijama practitioner to practice hijama/ cupping on myself.

Name: _____

Signature: _____ Witness: _____

Date: _____ Witness: _____