Hijama Cupping London - Medical History Form

Name: ________________________ Date of Birth: ________________

Address: ____

________________________ Email Address: ________________

Phone number(s): ______________________________________

Emergency contact:

Name: ________________________ Relationship: ________________

Phone Number: ______________________________________

Medical Information:

Any Illness' or concerns: ______________________________________

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	Yes	No
Are you taking medications at the moment?	☐	☐
If Yes, name of medicines ________________		
Do you have allergies/skin conditions? ________________	☐	☐
Have you had any recent surgery? ________________	☐	☐

If yes, Please specify: ______________________________________

Where/How did you learn about us?

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What are the main reasons why you wish to have Hijama today?

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Is there anything in particular you hope to improve with hijama?

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I have been told and understand the procedure for Hijama wet cupping therapy. I have seen the equipment. I give permission to the Therapist to administer dry/massage/wet cupping on my person. I allow the Practitioner to make small incisions on my skin surface and draw a small amount of toxic blood for the purposes of Islamic natural healing, in accordance to the Hijama therapy procedure. I am fully responsible for this decision and do not hold the Practitioner liable for any injuries or other outcomes.

Patient's Signature: ________________________ **Date:** ________________