

VOILÀ LA FAMILIA

PAULE-DOMINIQUE ANNEHEIM
MASSAGE THERAPIST CMT

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Pediatric Massage Information Form

Name: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Referred by: _____

Date of birth: _____ Grade in school: _____

Are you currently under a doctors care? _____ Doctor's name: _____

Birth history:

Premature? _____ Problems? _____ Breech position? _____ Caesarean? _____

Please check if you now have, or ever had problems with the following:

skin diseases _____ headaches _____ epilepsy or seizures _____
joint pain or swelling _____ contagious illness or disease _____ tension or soreness in a specific area _____
other pain _____ insomnia _____ extra sensitivity to touch or pressure _____

Any allergies? _____

How is your health in general? _____

Any chronic health problems? _____

Any operations in your lifetime? _____

injuries: _____ sprains: _____

broken bones: _____ dislocations: _____

concussions or other head injuries _____ car accidents: _____

Any other major trauma, such as falls or bicycle accidents?: _____

Any recent injuries, hospitalizations or illnesses? _____

Are you taking any medications? _____

How much stress have you been under recently? _____

Where does your body tend to store stress? For example, do you get headaches or stomachaches when you are worried about something? _____

Is there anything else you would like me to know? _____

When you receive a massage, you will not be touched in any area that would usually be covered by a bathing suit (shorts for boys, tow piece bathing suits for girls). Is there any other area that you do not want to be touched?

I understand that Voilà La Familia is not a substitute for medical examination and treatment. I further understand that massage is of the basic purpose of relaxation, release of muscular tension, and the enhancement of health through increasing circulation and energy flow.

By my signature below, I hereby agree that my child shall receive massage from Paule-Dominique Anneheim and I agree to remain on her premises unless that parent, the child, and the therapist are in agreement that the child may remain when the parent leaves.

I hereby give _____ permission to speak with my child's pediatrician if there are any issues of concern.

Signature of Parent or Guardian _____