BODY BALANCE Remedial Clinic

TJ BODY BALANCE Pty. Ltd
02 8041 7137 / 3G 9-13 Redmyre Rd Strathfield NSW 2135

NO.

## CLIENT MEDICAL RECORD

| | |
|---|---|
| Full name(이름): Moon-Bong Kang | Date(오늘날짜): 07. 10. 2023. |
| Address(주소): 1417 Carter ST | Gender(성별): M. |
| Suburb: Lidcombe Postcode: | DOB(생년월일): 27/12/61 |
| Mobile: 0416.284.820 | EMERGENCY CONTACT(비상연락) |
| E-mail: kamuberu@hotmail.com | Health fund(보험): bupa, Restoramt. |

**Type of Employment and work habits:** — Operation. won business.

**Leisure activities / level of exercise:** -

**Previous Massage Treatment:** ( yes / no )

| **Pre- Existing Condition/ Medical History** (Please list any illness/ operations- details & year) | **Current Medications** (please list e.g. Wolfren, Zoloft) |
|---|---|
| tear on Right shoulder joint tendon 4cm. | |
| **Fractures, Injuries, Accidents** (if yes, where and when? e.g. Right Tibia – broken 2003) | **Other medical issues**(family History, Implants, Allergies, etc e.g. Arthritis, pacemaker, allergy to nuts etc) |
| | |

**Please indicate whether you have any of the following conditions:**

| | | |
|---|---|---|
| High/Low Blood Pressure issue | Stroke | Cancer |
| Heart Condition/problems | Fainting / Blackouts | Problems with any organs |
| Asthma/ Chest conditions | Vertigo | Reproductive problems |
| Tuberculosis | Diabetes | Pregnant / trying to get |
| Thrombosis/Circulatory condition | Claustrophobia | Fluid retention |
| Hemophilia/ Bruising | Arthritis/ Joint Pain | Skin conditions / Allergies |
| Varicose Veins | Frozen Shoulder | Stress |
| Epilepsy | Migraines / headaches | Other |
| HIV positive/AIDS/Hepatitis | Sciatica / lumbago / back pain | |

**Main reason for your visit today:**(e.g. relaxation, de-stress, muscular tension relief, maintenance, specific remedial massage)

(R) tendonosis. 4cm tear

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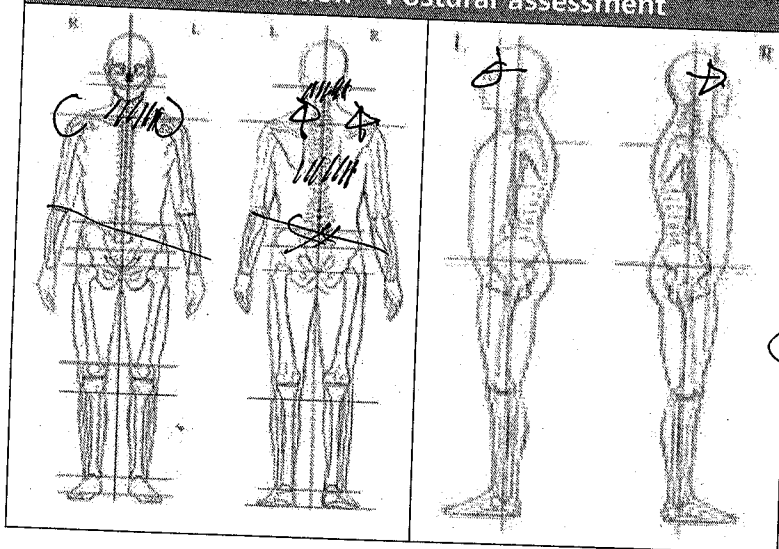
| Objective examination - Postural assessment | Notes - include R.O.M & palpation |
|---|---|
|  | head forward<br>shoulder rounded<br>upper-trap tight<br>SCM Scalen tight too.<br>R. PSis higher than<br>⇒ anterior tilt |

**Special tests – please include any special tests applied and the results from the test/s**

**Select a treatment plan**

**Remedial/Deep Tissue Massage/ Myofascial Release / Trigger points/ MET / Lymph/ Other**

chest fascia Release upper-trap SCM Scalen hip flexor ⇒ TrP

**Treatment – (Rx)**

" " same as above

**Alteration to treatment plan and reason why**

None

**Evaluate – subjective response to treatment: (the client response) – How they felt, responded,etc**

Relief tingling on feeding.

**Objective response to treatment: (Your response) – how the muscles responded, postural changes etc**

1. tone down

**Client education, recommendations/ further treatment**

**Home care advice: (Pilates training, stretching, strengthening exercise, postural, heat, cold, rest and other)**

Do not stay at toilet long time.

**Future treatment plan: (weekly, fortnightly, monthly, quarterly, Maintenance and other)**

| **Referrals:** | |
|---|---|
| **Manager** | Name: Signature: |

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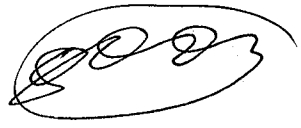
## CONSENT FOR TREATMENT

# I understand that:

- ✓ This is a massage treatment and is not a medical or allied health treatment (physiotherapy, osteopathy, chiropractic)
- ✓ I have viewed the therapists' qualifications
- ✓ The risks specific to my individual circumstances may have a bearing on my decision to proceed with the proposed treatment
- ✓ The therapist reviewed my health history before treatment commenced
- ✓ The therapist explained that the physical assessment I received may involve partial undressing and may require the therapist to palpate (touch) the area(s) of my body relevant to my presenting condition
- ✓ The therapist explained the treatment options to me
- ✓ The therapist explained the associated risk and possible side effects with the treatment options as described
- ✓ The therapist discussed the massage procedures, the areas of the body to be treated, the undressing and dressing procedures, the draping procedures and the positioning on the table for and during treatment
- ✓ The therapist established that the treatment session will be stopped should the treatment as first agreed to, require modification. The therapist will explain the reason for the change and any risks and/or side effects as a result of the change
- ✓ I can ask any questions in regard to any modification to the treatment plan. I should be totally comfortable with the explanation and reasoning for the change before consenting to the modification to the initial treatment plan
- ✓ The therapist has explained that I have the right to refuse treatment, to make changes to the treatment and to stop the massage at any time
- ✓ I have the right to request evidence for treatment that may include the abdomen, anterior and lateral chest, and buttock and / or groin areas. I understand I have the right to refuse treatment of these areas
  - ✓ If I agree to treatment to any of the areas mentioned in the point above, I may be requested, by the therapist, to complete a consent form relevant those areas

## ONLY SIGN BELOW IF THE ABOVE INFORMATION IS UNDERSTOOD AND HAS OCCURED

| Client name: | Signature: | Date: |
|---|---|---|
| moon-Bong kang |  | 07.10.2023 |
| **Parent/guardian name:** | **Signature:** | **Date:** |
| | | |
| **Therapist name:** | **Signature:** | **Date:** |
| Phillip Joe Yoon |  | " |