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): 조 효 은 CHOHYOEUN	Date(오늘날짜): 10.14.2023
Address(주소): 1 Brushbox St	Gender(성별): W (F).
Suburb: Postcode:	DOB(생년월일): 12.12.1991
Mobile: 0403461203	EMERGENCY CONTACT(비상연락)
E-mail: sosjss@naver.com	Health fund(보험):

Type of Employment and work habits: . pilates instruction.

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)
- C8. - L4 & L5.	
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). - Shoulder.
⇒ R.O.M

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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: CHOHYOEUN	**Signature:**	**Date:** 14.10.23
Parent/guardian name:	**Signature:**	**Date:**
Therapist name: Phill-Jae Yoon	**Signature:**	**Date:** 14.10.23

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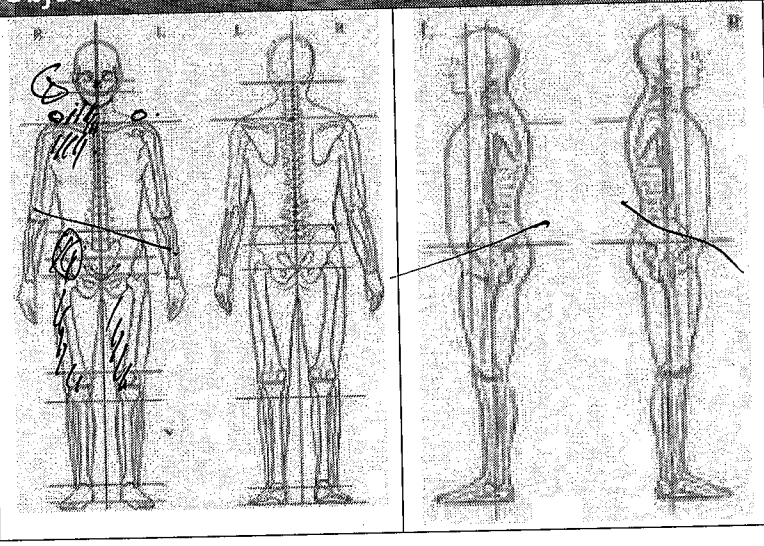
NO.

Objective examination - Postural assessment	Notes - include R.O.M & palpation
	Scalens tight. Reduced ROM Abuction. (R). anterial tilt (R). ITB. hipflexors tight. (L) Abductors tight.

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

Pectralis major and minor upper traps. scm scalens. hipflexors

Treatment – (Rx)

Alteration to treatment plan and reason why

No

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

good.

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

improved R.O.M
changed tilted pelvics level.

Client education, recommendations/ further treatment

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

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

Referrals:

Manager Name: Signature: