Tarrengower Remedial Massage

CLIENT RECORD: Follow-up Consultation

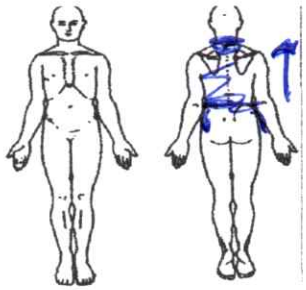
Last Name: Linda First Name: Hickey Date 29/4/22

Area Being Treated Cx

Current Presentation LOOTRADIOPS:

Has your Clinical Impression changed? Y (N)
If yes

Response to previous treatment (+'ve, -'ve ISQ): +'ve



@ ESq T Cx - Lev Scap U/T scalene

@ Glute Med

Client consent for treatment

Please sign L M Hickey Date 29/4/22

OBJECTIVE EXAMINATION:

Observation:

Palpatory **Assessment:**
Longissimus, Iliocostalis Hypertonic

Treatment:
MFFT ESh, U/T, Lev Scap, Post Scalene.
MFFT - Glute Med (b. lat)
DIP MTrP: Glute med, U/T, Lev Scap, Post Scalene

Reassessment & Postural **Improvements:**
Cx Rotn L 60° ↑ @ U/T
R 70° P1 @ U/T
Cx Lat flex L 30° S1 @ U/T
R 40° S1 @ U/T

Motion tests (Active, Passive, Resisted, Special Tests):
Cx Rotn R 45° P1 @ U/T
60° P1 @ U/T.

Cx lat flex L 100 P1 @ Post Scalene
R 150 S1 @ " "

Cx Flex 1 finger S1 @ L U/T.

Advice & Corrective Exercises:
Cx Rotn & lat flex Stretch. 2x b.lat 20 Sec hold

Next Treatment/Management Plan:

PATIENT SCREENING QUESTIONNAIRE FOR COVID-19

Please Circle Yes or No

1. Are you fully vaccinated against Covid-19? **Yes** **No**
    a. If no are you booked in for your vaccination or booster? **Yes – Date** ___/___/_____
    No
2. Do you have a fever or Respiratory Symptoms? **Yes** **No**

Symptoms include fever OR an acute respiratory infection and include (but are not limited to) cough, sore throat, fatigue and shortness of breath with or without a fever.

3. Have you been identified as a close contact of a confirmed case of coronavirus? **Yes** **No**

A close contact is someone who has been face to face for at least 15 minutes, or been in the same closed space for at least 2 hours with someone who has tested positive for the COVID-19 when that person was infectious.

4. Have you returned from overseas within the last 14 days? **Yes** **No**
5. Are you waiting on COVID-19 swab results? **Yes** **No**
6. Have you been asked to self-isolate by your GP, or a government authority? **Yes** **No**
7. Have you received a COVID-19 vaccination in the past 3 days? **Yes** **No**

I, the undersigned hereby declare that the information I have provided in this questionnaire is true and accurate

Name Linda Hickey

Your signature L M Hickey

Date 29/4/22