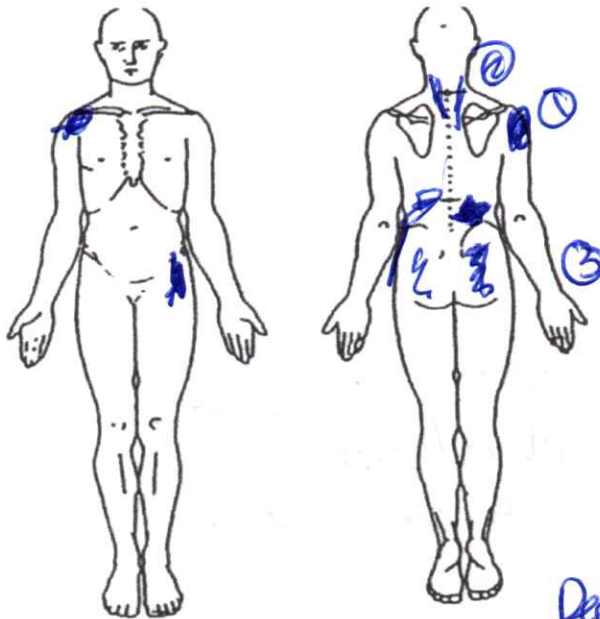


Name: Lynne McShanag.

Indicate site or pain and referral area

Site of restriction

Location of pain/restriction/other: _____

fractured Pelvis - ② Schium
→ Schium ③ Schium - healed.R Shldr - adhesive Caps.
PTSD?DeepOnset - Initial (when/how it first began): 7yrs - acute on ChronicNow (current presentation): Sore ①Other Symptoms: Referral → low Scap? U/t.Type of Pain: aching, burningReferral Pain: ↑ head R calf → foot. (L4,5)?What aggravates the pain? Pressure on ② Shoulder, ③ Hip
coldDegree of Pain (0-10): _____ Irritability Level: Low _____ Med _____ HighWhat Offsets / Alleviates the Pain? Movement, Stretch, hot bathPast Treatments & Results: Massage ✓, Chiro ✗Special Questions (may also be specific to region): Shoulder pain waking up at night.
cold**OBJECTIVE EXAMINATION** - Body Type: Hypomobile 0-1 (✓) Average 2-4 () Hypermobile 5-9 ()**Observation**

Posterior view <u>R Scap</u> <u>ASIS RA</u> <u>ADG L4</u> <u>R3.5.</u>	Anterior view <u>RCWLL ↓</u> <u>ACR ↓</u> <u>ASIS R ↓</u>	Lateral view <u>APT</u> <u>R > 2.0cm</u> <u>L = 1.5.</u>
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Motion Tests

<p>Active (P1, S1, PB)</p> <p>shld Flex L 180° S₁@ ant delt R 160° P₁@ Teres Minor</p> <p>shld abd L 180° PB R 90° S₁@ biceps L</p> <p>Cx Rtn L 60° S₁@ U/T R 45° S₁@ Post</p> <p>Cx Lat Flex L 100° Scal ^{100° Trans. cap} _{100° cap} ^{Scal} _{100° cap} R 100° Scal ^{100° Trans. cap} _{100° cap} ^{Scal} _{100° cap}</p>	<p>Passive [P1, S1, R1]</p>
<p>Resisted</p> <p>Hor shldr abd R ✓ L ✓</p>	<p>Functional/Special Tests</p> <p>Trendelenberg - R +ve L -ve</p> <p>Hawkins/Kennedy - 1ve</p> <p>empty can - 1ve</p>

Palpatory Assessment: Chronic Hypertonicity through Lx

Clinical Impression: _____

<p>Treatment</p> <p>MFTT - TLF, Lat Roesi, U/T, lat Scalp Glute Med, Post scalene supra, infra, Teres Min</p> <p>DIP - MTRP - Supra, Infra, Teres Min U/T, Glute Med, Rhomb.</p>	<p>Reassessment</p> <p>Cx Rtn L 70° S₁@ Physma R 60° S₁@ ant Scalp</p> <p>Cx Lat Flex L 20° S₁@ Post Scalp R 15° B₁@ supra cap</p>
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Corrective Exercises

Exercise	Sets	Reps	Other Advice
Cranstells	2	3	Breat while watching TV

Postural Improvements: _____

Treatment Goals / Management Plan: 2 weeks - booked

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 to those areas

Only sign below if the above information is understood and has occurred

Client
Name: LYNN MESSANAY Signature: [Signature] Date: 18/6/2022

Parent/Guardian
Name: _____ Signature: _____ Date: _____

Therapist
Name: Paul Gilders Signature: [Signature] Date: 13/6/22

PATIENT SCREENING QUESTIONNAIRE FOR COVID-19

Please Circle Yes or No

1. 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.

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

You are a close contact if you: live in the same house as someone who tests positive. spent 4 hours or longer with someone in a home, or health or aged care environment.


3. Are you waiting on COVID-19 swab results? **Yes No**

4. Have you been asked to self-isolate by your GP, or a government authority? **Yes No**

5. 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 LYNN MESHANAC

Your signature 

Date 13 / 6 / 2022