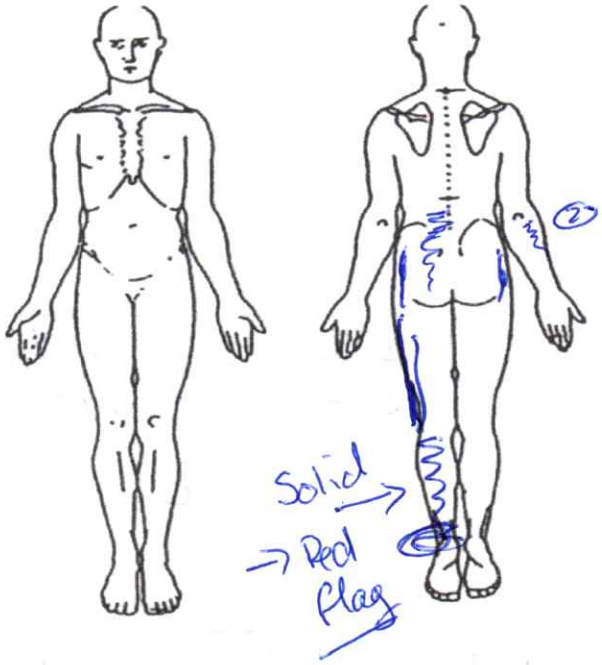
TARRENGOWER REMEDIAL MASSAGE

Date 18 / 6 / 2022
Initial Consultation Form

Name: Neil McLean



Indicate site or pain and referral area

Site of restriction

Location of pain/restriction/other:

Retired – Truck Driver.

Piriformis Syndrome?

ITB? → TFL ↓

Onset - Initial *(when/how it first began)*: chronic

Now (*current presentation*): Weak → Throb.

Other Symptoms: Referral ↓ leg.

Type of Pain: Throbbing constant

Referral Pain: lower leg

What aggravates the pain? Sitting

Degree ofPain (0-10): 8-10 Irritability Level: Low ____ Med ____ (High)

What Offsets / Alleviates the Pain? ~~Sitting~~ laying down

Past Treatments & Results: Massage – not effective

Special Questions *(may also be specific to region)*: Painkillers?

Worse in morning – NO

OBJECTIVE EXAMINATION - **Body Type:** Hypomobile 0-1 ( ) Average 2-4 (✓) Hypermobile 5-9 ( )

Observation

Posterior view	Anterior view	Lateral view
R Scap ↑ L PSIS ↑ ADh L 5 R 3.5	R Clavl ↑ : Shldr In Rot	L Plumb ✓ R knee Mac.

Motion Tests

Active *(P1, S1, PB)*	Passive *[P1, S1, R1)*
Lx Flex Mid Shin P, @ (L) lat calf.	
Resisted	**Functional/Special Tests**
	SLR 90° ~~R (S)~~ S. @ lateral calf. 85° ~~R (S)~~ S @ H/S Trendelenburg L -ve R +ve

Palpatory Assessment: (L) calf very hard to palpate - Ultrasound on 6 July
→ Red Flag - local - calf

Clinical Impression: Sciatic nerve pathway impingement? caused by obesity & sedentary lifestyle

Treatment	Reassessment
MFTT: TLF, QL, Glute Med Glute Max TFL, H/S. DiP MTrP- Glute Max, Glute Med, Piriformis	Lx Flex improvement 2 cm

Corrective Exercises

Exercise	Sets	Reps	Other Advice
Piriformis	2	3	every 2nd day → point of Stretch → Hold 20 sec

Postural Improvements:

Treatment Goals / Management Plan: 2 weeks - booked

* Neil is planning on returning to aquatic exercise to assist in weight loss

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 Neil McGregor

Your signature

Date 19/6/22