Tarrengower Remedial Massage

CLIENT RECORD: Follow-up Consultation

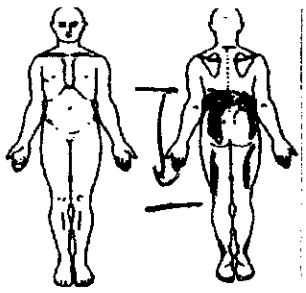
Last Name: M'LEAN First Name: NEIL Date 16/7/22

Area Being Treated _____

Current Presentation LOOTRADIOPS:

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

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



① Piriformis
② lower back
2-3 days relief
Good in morning after 1 hour weight bearing deteriorates
lower back

Client consent for treatment

Please sign _____ Date 16-7-22

OBJECTIVE EXAMINATION:

Observation:
GP Visit on ~~Monday 18 July~~ Wed 20th

Palpatory **Assessment:**

Treatment:
MFTT Post Chain LX ↓ H/S
DIP MT, P Calute Med Piriformis
P&S Piriformis.

Reassessment & Postural **Improvements:**
SLR = 85° Bilat
HIP Flex - 110° Bilat

Motion tests (Active, Passive, Resisted, Special Tests):

Advice & Corrective Exercises:

Next Treatment/Management Plan: _____

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 Keith McLean

Your signature

Date 16/7/22