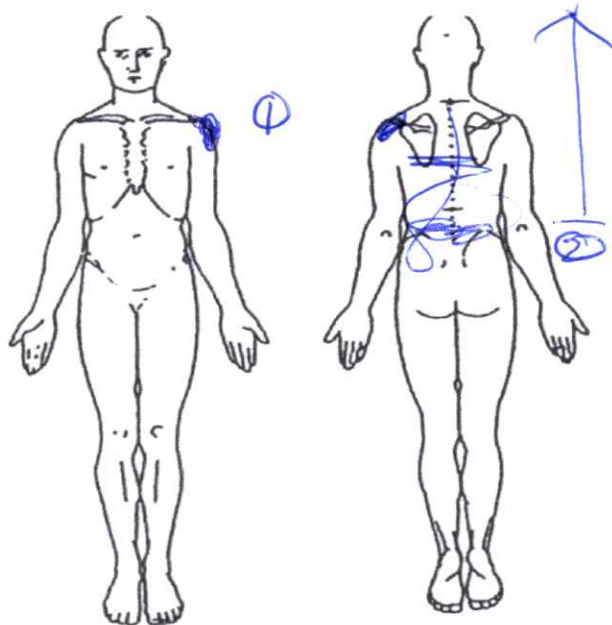


Name: Ken Hercott

Indicate site or pain and referral area

Site of restriction

Location of pain/restriction/other: _____

① Shoulder - dislocation?② Bx PainOnset - Initial (when/how it first began): ① Acute
② Chronic → Acute on ChronicNow (current presentation): ① 1/10
② comes & goesOther Symptoms: ① None indicated ② None indicatedType of Pain: ① Sharp initiallyReferral Pain: ① No ② NoWhat aggravates the pain? ① Tilting - Bending, chainsawingDegree of Pain (0-10): ① 8/10 Irritability Level: Low _____ Med ① High _____What Offsets / Alleviates the Pain? rest heatPast Treatments & Results: massage - good resultSpecial Questions (may also be specific to region): Shoulder pain woke Ken
@ night

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

Observation

| | | |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| Posterior view <u>PSIS ✓</u> <u>SCAP. ✓</u> <u>Adh = 4-5</u> | Anterior view <u>ASIS ✓</u> <u>MCR ✓</u> <u>CLVL ✓</u> <u>Inwardly for shoulders</u> | Lateral view <u>Phmp L&R</u> <u>APT = 1.0 B. ext</u> |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|----------------------------------------------------------------|

Motion Tests

| | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| <p>Active (P1, S1, PB)</p> <p>Shld ABD 2 160° S₁ @ Triceps R 180° P₁ @ Lat.</p> <p>Shld ext L 180° PB R 180° PB</p> <p>Lx Flex 1/2 Sum S₁ @ Calves Lx cat flex 1/2 knee S₁ @ ex obl</p> | <p>Passive (P1, S1, R1)</p> |
| <p>Resisted</p> <p>R " " " "</p> | <p>Functional/Special Tests</p> <p>Hawkins Kennedy - UK</p> <p>SLR L 450 R, Springsy R 450 R, Springsy</p> <p>Obers</p> |

Palpatory Assessment:

Post Delt tender

Clinical Impression: _____

| | |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| <p>Treatment</p> <p>MFTT ES, Traps Post Delt, Triceps, Lat</p> | <p>Reassessment</p> <p>L Shldr, ABP 180° P₁ @ ant Delt Lx Flex + Sum S₁ @ Calves.</p> |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|

Corrective Exercises

| Exercise | Sets | Reps | Other Advice |
|----------|-------|-------|----------------------------------|
| _____ | _____ | _____ | Triceps / Post Delt Stretch with |
| _____ | _____ | _____ | Theraband |
| _____ | _____ | _____ | _____ |

Postural Improvements: _____

Treatment Goals / Management Plan: 2 weeks @ 6:30

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 novel 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.

3. Have you returned from overseas within the last 14 days? Yes **No**

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

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

6. Have you received a COVID-19 vaccination in the past 3 days? Yes **No**

7. (Clinic only) Have you checked in? **Yes** No

8. (Mobile only) How many visitors have been to your house today? ____

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

Name Ken Hercott

Your signature 

Date 14/10/2021

CHECK-IN NOW



Tarregower Remedial Massage



Unable to scan? Download the
Service Victoria app and use code:

QDG Z6Q