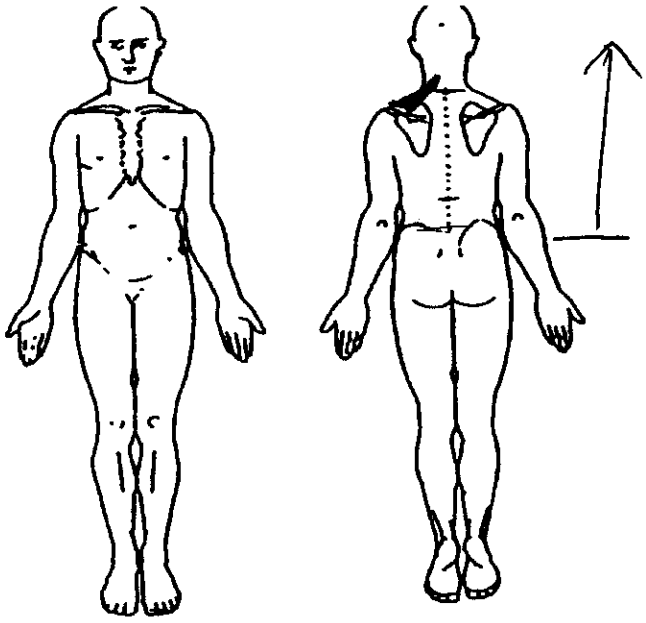
TARRENGOWER REMEDIAL MASSAGE

Date 2/3/22

Initial Consultation Form

Name: Jane Hosking



Indicate site or pain and referral area

Site of restriction

Location of pain/restriction/other:

(L) U/T ? Lev Scap

event manager

Hx - Frozen Shoulder

Onset - Initial *(when/how it first began)*: Setting Up for event 3/52

Now *(current presentation)*: 2/10 - 3/10 (compensating)

Other Symptoms: None indicated

Type of Pain: Tight, sometimes hot

Referral Pain: Up neck, down Deltoids

What aggravates the pain? moving out of range

Degree of Pain (0-10): 6/10 Irritability Level: Low ____ Med ____ (High)

What Offsets / Alleviates the Pain? Heat

Past Treatments & Results: None

Special Questions *(may also be specific to region)*: pain @ night, wake @ night → panadol

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

Observation

Posterior view	Anterior view	Lateral view
R Scap ↑ AOG L 4 R 3.5 L PT R ↑	Shldrs Int rot L PT R ↑	Rounded ✓

Motion Tests

Active *(P1, S1, PB)*	Passive *[P1, S1, R1)*
Shldr Abd R 180° PB L 180° S.@ triceps. Ext R 180° PB L 170° S.@ triceps Cx Rotn L 65° PB R 45° PB Cx Lat L 30° S.@ U/T R 20° S.@ U/T	
Resisted	**Functional/Special Tests** Scar adhesion +ve R -ve L.

Palpatory Assessment:

Clinical Impression: _____

Treatment	Reassessment
MFTT: TLF, ESA, U/T, Lev Scap DIP MIP U/T, Lev Scap, Supra Spinatus	Cx Rotn L 80° PB R 60° PB Cx lat flex L 40° PB R 40° S.@ Scalenes

Corrective Exercises

Exercise	Sets	Reps	Other Advice
Cx Stretch	___	___	Hold for 20 sec 1x each side daily.
	___	___	
	___	___	

Postural Improvements: _____

Treatment Goals / Management Plan: _____

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: Jane Hiting Signature: _____ Date: 4/3/2022.

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

Therapist
Name: Paul Gilders Signature: _____ Date: 7/3/22

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** 4/3/2022
   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**
8. (Clinic only) Have you checked in? **Yes** **No**

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

Name Jane Hitchy

Your signature

Date 4/3/2022

CHECK-IN NOW

Tarrengower Remedial Massage

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

QDG Z6Q