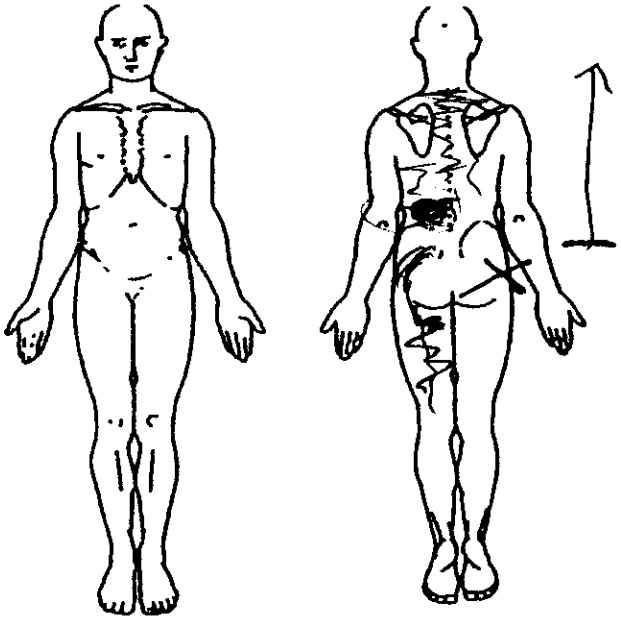
TARRENGOWER REMEDIAL MASSAGE

Date 7/7/2022
Initial Consultation Form

Name: Lois Lark[redacted]



Indicate site or pain and referral area

Site of restriction

Location of pain/restriction/other:

① Hip. Replacement
② Lower back.
③ Arthritis in Spine

Onset - Initial *(when/how it first began)*: MOI unknown chronic / Acute on Chronic 3/12 ago

Now *(current presentation)*:

Other Symptoms: None indicated (Hip Replacement)

Type of Pain: Rapid - improves when tightening

Referral Pain: none indicated

What aggravates the pain? moving

Degree of Pain (0-10): 7/8. Irritability Level: Low____ Med____ (High) (on & off)

What Offsets / Alleviates the Pain? Heat / cold (Hot water bottle)

Past Treatments & Results: Myotherapy, Physiotherapy - degrees of Success

Special Questions *(may also be specific to region)*: No Referal, & can wake Lois at night. Tramadol this morning

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

00 **Observation**

00

Posterior view	Anterior view	Lateral view
Scap ↓ ACs = 4 Bilat L PSIS ↓	CLVL ↓ ↓ Lat Protracta Slight Int Rot	Plumb ✓

Motion Tests

Active *(P1, S1, PB)*	Passive *(P1, S1, R1)*
Note: NO Lx flex } Hip replacement	
Resisted	**Functional/Special Tests**

Palpatory Assessment:

Clinical Impression: _____

Treatment	Reassessment
MFTT: T1-10 Costales, TLF, Glute Med, Glute Max, H/S. MFTT: Longissimus, TRAPEZIUS, Lev Scap.	

Corrective Exercises

Exercise	Sets	Reps	Other Advice
			Tx Rotn (seated)

Postural Improvements: _____

Treatment Goals / Management Plan: monitor & book when req'd.

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
me: LOIS LARKMAN Signature: [signature] Date: 7/7/22

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

Therapist
Name: Paul Gilders Signature: [signature] Date: 7/7/22

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 ff Hurtzman LOIS HURKMAN

Your signature _____

Date 7/7/22