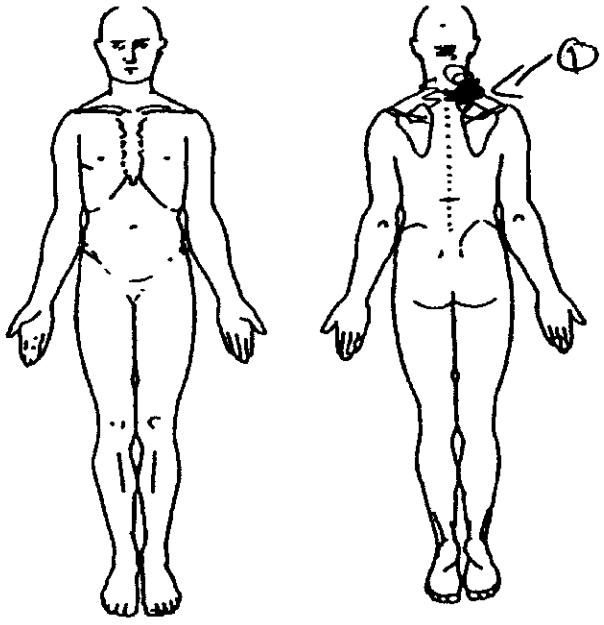
30/10/21 JESS CARR

TARRENGOWER REMEDIAL MASSAGE

Initial Consultation Form



Indicate site or pain and referral area

Site of restriction

Location of pain/restriction/other:

(R) Cx ↗ subocc
Lev Scap.

History of tension headaches

Onset - Initial *(when/how it first began)*: 1/52

Now *(current presentation)*: Tight 4-5/10 ↗ 7-8/10

Other Symptoms: Dull headach

Type of Pain: Dull ache.

Referral Pain: None Indicated

What aggravates the pain? Sitting at computer, sudden movement

Degree of Pain (0-10): 8/10 Irritability Level: Low — (Med) — High

What Offsets / Alleviates the Pain? Warm Shower, heat pack

Past Treatments & Results: Osteo - Un Changed

Special Questions *(may also be specific to region)*: IBUPROFEN 1-2 day
wakes at night, stiff in morning, improves

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

Observation

Posterior view	Anterior view	Lateral view
R Scap ↑ PSIS ✓ AOG = 3.5 Rs Planus.	R ACR ↑ ASIS ✓ Skin int	Plumb GT → Knee ← Mal ←

AOT = 1.5"
FHC = 1

1 1
1 1
0 0
0
1 1

Motion Tests

Active *(P1, S1, PB)*	Passive *(P1, S1, R1)*
Cx Flex c Fingers S, @ U/T Cx Ext S, @ R U/T Cx Rot L 40° S, @ U/T R 40° P, @ U/T L 30 S, @ U/T R 30 P, @ U/T.	
Resisted	**Functional/Special Tests**
	Scap offload

Palpatory Assessment: Tight ESC & U/T

Clinical Impression: _____

Treatment	Reassessment
MFTT ESC, U/T, Lev scap Infra Spinatus DiP Infra Spinatus Cupping U/T, Lev Scap.	Cx Rotn R 70° P, @ U/T L 65° S, @ U/T LAT flex L 40° S, @ U/T R 40° P, @ UT

Corrective Exercises

Exercise	Sets	Reps	Other Advice
			Cx Stretch

Postural Improvements: _____

Treatment Goals / Management Plan: _____

PATIENT SCREENING QUESTIONNAIRE FOR COVID-19

Please Circle Yes or No

1. Have you received both Covid Vaccinations? **Yes** **No**
    a. If no are you booked in for your vaccination? **Yes – Date** ___/___/_____ **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.

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 Jessica Carr

Your signature

Date 30 / 10 / 21

CHECK-IN NOW

Tarrengower Remedial Massage

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

QDG Z6Q