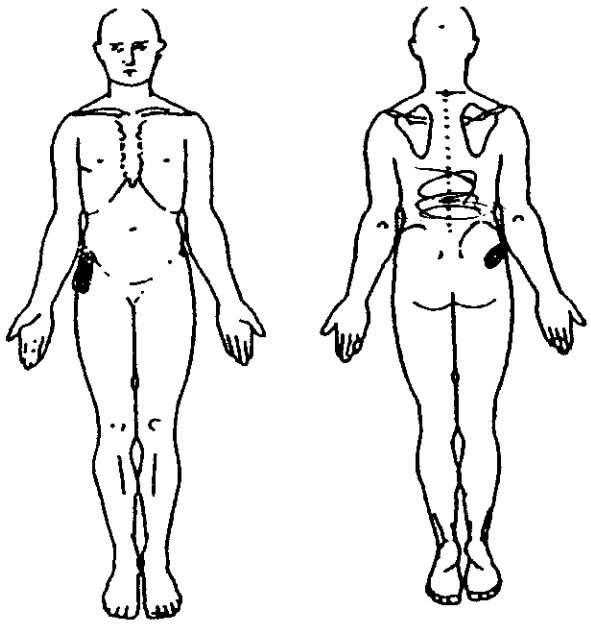
TARRENGOWER REMEDIAL MASSAGE

Date 30 / 10 / 2023
Initial Consultation Form

Name: Michael Farr



Indicate site or pain and referral area

Site of restriction

Location of pain/restriction/other:
Hip / Back
Dead lift / Squats
2x week
walking 5x week
crossfit 1x week
running.

Onset - Initial *(when/how it first began)*: Acute on chronic
Now *(current presentation)*: restricted.

Other Symptoms: none indicated
Type of Pain: dull ache → sharp.
Referral Pain: front of leg.
What aggravates the pain? Sitting

Degree of Pain (0-10): _____ Irritability Level: Low ____ (Med) ____ High
What Offsets / Alleviates the Pain? Heat, stretch

Past Treatments & Results: Physio → exercises

Special Questions *(may also be specific to region)*: not waking at night

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

Observation

Posterior view	Anterior view	Lateral view
hip L 35 R 45		

Motion Tests

Active *(P1, S1, PB)*	Passive *(P1, S1, R1)*
Lx flex ~~ankle~~ Mid Shin S@H/S	Hip Flex L 90° R (spring) R 90° R (spring)
Resisted	**Functional/Special Tests**
	SLR L 60° S@ H/S. R 45° S@ semi bend ~~PRBB~~

Palpatory Assessment:

Clinical Impression: _____

Treatment	Reassessment
MFR Reclem, Vas Lat, TFL Vas Med, Psoas Maj, CMed MET Hip Flex GMax PBS Reclem	

Corrective Exercises

Exercise	Sets	Reps	Other Advice
Reclem Shield	2	2	Hold 20 Sec
TFL 1L	2	2	" " "

Postural Improvements: _____

Treatment Goals / Management Plan: 2 weeks (booked)