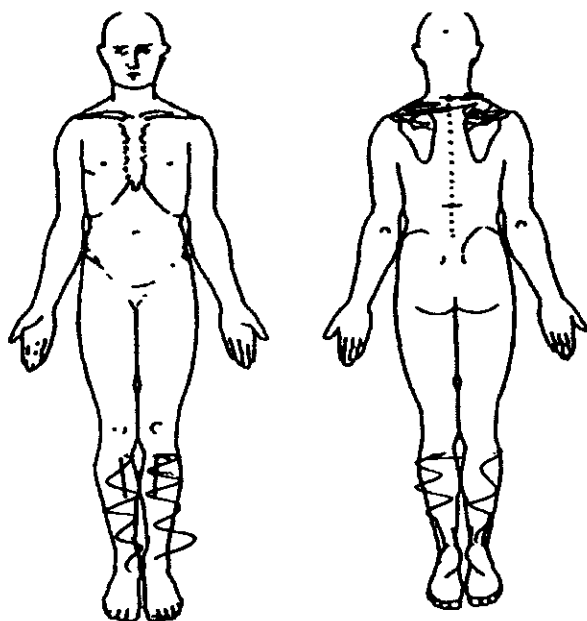


Date 22/11/21

Initial Consultation Form

Name: Katie

Indicate site or pain and referral area

Site of restriction

Location of pain/restriction/other: \_\_\_\_\_

Started running 3/12  
7.4 km  
3x per week

Onset - Initial (when/how it first began): 3/12Now (current presentation): Tight → TiredOther Symptoms: none indicatedType of Pain: Tightness

Referral Pain: \_\_\_\_\_

What aggravates the pain? UphillDegree of Pain (0-10): \_\_\_\_\_ Irritability Level: Low Med HighWhat Offsets / Alleviates the Pain? RestPast Treatments & Results: Not for running

Special Questions (may also be specific to region): \_\_\_\_\_

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

## Observation

Posterior view L SCAP ✓ PSIS ✓ AOC 1 3 3	Anterior view CLV ✓ ACR ✓ shldr int (slight)	Lateral view Pumb h ✓ R ✓ API = 1.5.
---	---	--

## Motion Tests

Active (P1, S1, PB)	Passive (P1, S1, R1)
Resisted	Functional/Special Tests SLR R 85° L 75°

Palpatory Assessment:

Clinical Impression: \_\_\_\_\_

Treatment MIFTT : Posterior Chain : - ESF, H/S, Calves : UIT, Lev Scap.	Reassessment
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## Corrective Exercises

Exercise	Sets	Reps	Other Advice
_____	_____	_____	Stretches - Adductor
_____	_____	_____	Glute Med.
_____	_____	_____	_____

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 Katie Petrusma

Your signature [Signature]

Date 22/11/2021

**CHECK-IN NOW**



Tarrengower Remedial Massage



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

**QDG Z6Q**