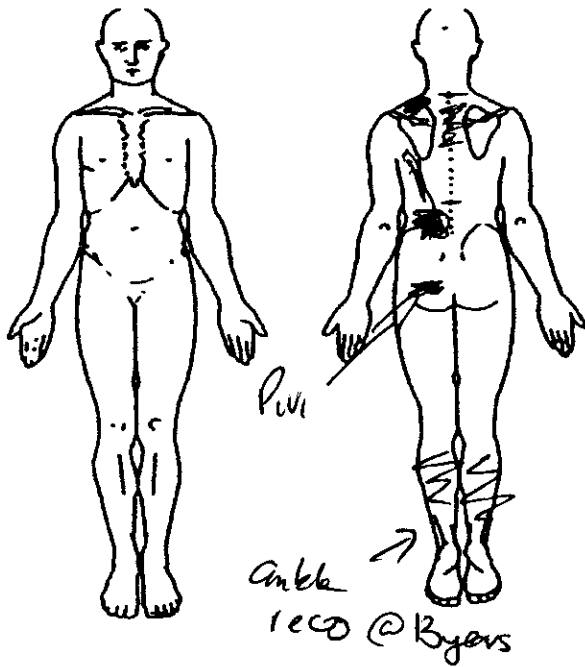


Name: Danna Petruska

Indicate site or pain and referral area

Site of restriction

Location of pain/restriction/other: _____

Onset - Initial (when/how it first began): ChronicNow (current presentation): comfortable - load has been reduced
→ rested

Other Symptoms: _____

Type of Pain: _____

Referral Pain: _____

What aggravates the pain? Running (extra load)TechniqueDegree of Pain (0-10): _____ Irritability Level: Low Med HighWhat Offsets / Alleviates the Pain? Rest / massage - slow ramp upPast Treatments & Results: Massage, Osteo

Special Questions (may also be specific to region): _____

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

Observation

Posterior view	Anterior view	Lateral view
<u>Qsk'dr</u>		

00
00
00
00

Motion Tests

Active (P1, S1, PB)	Passive (P1, S1, R1)
Resisted	Functional/Special Tests

Palpatory Assessment:

Clinical Impression: _____

<p>Treatment</p> <p>MFTT & DIP, Gastroc, H/S, P.iformis, ESG, U/T, Lat Scap, Lat. Dorsi</p>	<p>Reassessment</p>
---	---------------------

Corrective Exercises

Exercise	Sets	Reps	Other Advice
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Postural Improvements: _____

Treatment Goals / Management Plan: _____

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 novel 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

Donna Petersma DONNA PETERSMA

Your signature

Donna Petersma

Date

20/9/21

CHECK-IN NOW



Tarregower Remedial Massage



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QDG Z6Q