

Tarregower Remedial Massage

CLIENT RECORD: Follow-up Consultation

Last Name: PETRUSMA First Name: DONNA

Date 11/10/21

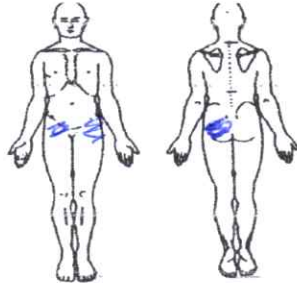
Area Being Treated _____

Current Presentation LOOTRADIOPS:

Has your Clinical Impression changed? Y N

If yes _____

Response to previous treatment (+ve, -ve/SQ): flow



Power lifting

Client consent for treatment

Please sign

Donna Petrusma

Date

11/10/21

OBJECTIVE EXAMINATION:

Observation:	Motion tests (Active, Passive, Resisted, Special Tests): <u>Thomas test</u>
Palpatory Assessment:	
Treatment: <u>MFTT (DIP) Lev Scap, Piriformis</u> <u>MFTT</u> <u>U/T, Thoracolumbar, Glute Med, Glute max</u>	Advice & Corrective Exercises:
Reassessment & Postural Improvements:	

Next Treatment/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? 0

I, the undersigned hereby declare that the information I have provided in this questionnaire is true and accurate

Name

Donna Petrus

Your signature

DONNA PETRUS

Date

11 / 10 / 21

CHECK-IN NOW



Tarregower Remedial Massage



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QDG Z6Q