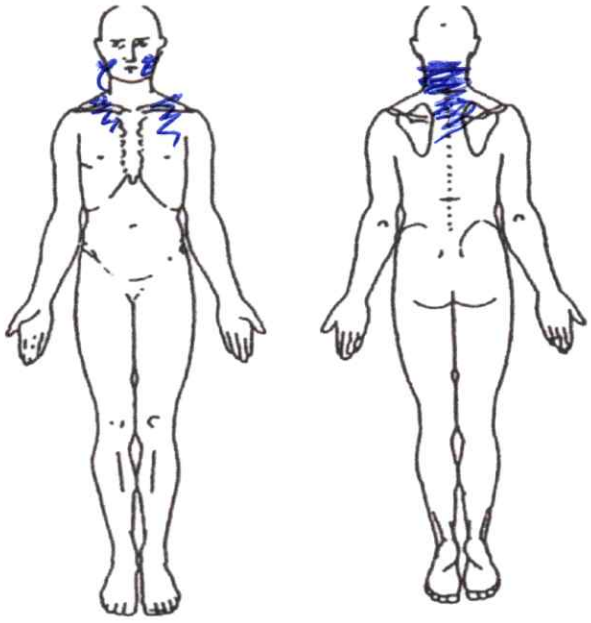
TARRENGOWER REMEDIAL MASSAGE

Date 7 / 1 /22
Initial Consultation Form

Name: Deb Anthony



Indicate site or pain and referral area

Site of restriction

Location of pain/restriction/other:
Cx / Tx
Sore waking up.
Sore when eating

Onset - Initial *(when/how it first began)*: 2/7

Now (*current presentation*): 7/10

Other Symptoms:

Type of Pain: ache → if moves, sharp.

Referral Pain: none indicated

What aggravates the pain? moving

Degree ofPain (0-10): 7/10 Irritability Level: Low ___ (Med) ___ High

What Offsets / Alleviates the Pain? sitting still, panadol & Ibuprofen

Past Treatments & Results:

Special Questions *(may also be specific to region)*: ~~bad~~ trouble sleeping consistent

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

Observation

Posterior view	Anterior view	Lateral view
L & R SCAPT ↑ PSIS ✓ AOG 3.5 3.5	Cx (L) TILT R CLAVCL ↑	APT 1.5. Phmn A

Motion Tests

Active *(P1, S1, PB)*	Passive *[P1, S1, R1)*
Cx Rotn L 30° P1 @ U/T R 30° S1 @ U/T Cx Lat flex R 60° S1 @ U/T. (4) L 50° S1 @ U/T (R)	
Resisted	**Functional/Special Tests** Scap offload. +ve Bilat

Palpatory Assessment:

Clinical Impression: _____

Treatment	Reassessment
MFTT ESG, U/T, Supra, LevScap	Cx Rotn L 50° S1 @ U/T R 40° S1 @ U/T Cx Lat flex R 30° S1 @ U/T L 20° S1 @ U/T

Corrective Exercises

Exercise	Sets	Reps	Other Advice
Cx Lat Stretch	___	___	Leave until Sunday,
	___	___	
	___	___	

Postural Improvements: _____

Treatment Goals / Management Plan: call if needed in a week

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**

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

Name Debra Anthony

Your signature

Date 7/01/21

CHECK-IN NOW

Tarrengower Remedial Massage

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

QDG Z6Q