

# Tarregower Remedial Massage

## CLIENT RECORD: Follow-up Consultation

Last Name: HICKER First Name: LINDA

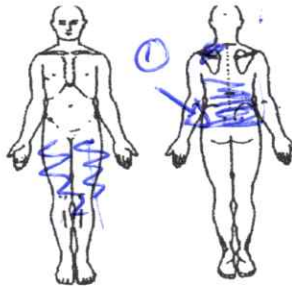
Date 22/4/22

Area Being Treated Lx/Rx

Current Presentation LOOTRADIOPS:

Has your Clinical Impression changed? Y<sup>N</sup>  
 If yes \_\_\_\_\_  
 \_\_\_\_\_

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



1 Hip  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Client consent for treatment

Please sign L.M. Buckley

Date 22/4/22

### OBJECTIVE EXAMINATION:

<p>Observation:</p>	<p>Motion tests (Active, Passive, Resisted, Special Tests):  <u>Lx/Rx Flex ankle S.@ Gastroc</u>  <u>Lx/Rx Lat Flex @ 2cm ↑ knee S.@ TLE</u>  <u>@ 2cm ↑ knee S.@ TLE</u></p>
<p>Palpatory Assessment:</p>	<p>Advice &amp; Corrective Exercises:  <u>Seated H/S &amp; Gastroc Stretch</u></p>
<p>Treatment:  <u>MFTT ESC, H/S Calves, Pecten</u>  <u>DIP MTRP Glute med, max</u>  <u>Stripping - calves</u></p>	
<p>Reassessment &amp; Postural Improvements:  <u>Lx/Rx Flex ankle S.@ gastroc</u>  <u>Lx/Rx lat flex L knee S.@ TLE</u>  <u>R knee S.@ TLE</u></p>	

Next Treatment/Management Plan: Next week - Glute Med treatment & Per femur L Run & stretch

PATIENT SCREENING QUESTIONNAIRE FOR COVID-19

Please Circle Yes or No

1. Are you fully vaccinated against Covid-19? **Yes** No  
a. If no are you booked in for your vaccination or booster? **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.
4. Have you returned from overseas within the last 14 days? **Yes** **No**
5. Are you waiting on COVID-19 swab results? **Yes** **No**
6. Have you been asked to self-isolate by your GP, or a government authority? **Yes** **No**
7. Have you received a COVID-19 vaccination in the past 3 days? **Yes** **No**
8. (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 LINDA HICKEY

Your signature *Linda Hickey*

Date 22/4/22

**CHECK-IN NOW**



Tarrengower Remedial Massage



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**QDG Z6Q**