

# Tarregower Remedial Massage

## CLIENT RECORD: Follow-up Consultation

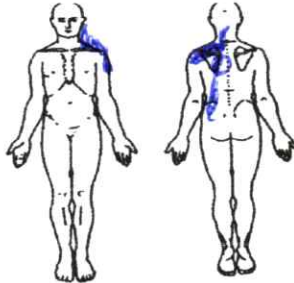
Last Name: HICKEY First Name: LINDA

Date 5/5/23

Area Being Treated Cx/Shoulder Current Presentation LOOTRADIOPS:

Has your Clinical Impression changed? Y N  
If yes \_\_\_\_\_

Response to previous treatment (+ve, -ve ISQ): True



② Side sore due to stepping in hole

① Cx very sore

### Client consent for treatment

Please sign L.M. Hickey

Date 5/5/23

### OBJECTIVE EXAMINATION:

Observation:	Motion tests (Active, Passive, Resisted, Special Tests): Cx Rotn L 30° P. @ U/T R 45° P. @ U/T Cx Lat Flex 50° P. @ U/T 10° P. @ U/T Lx Flex 5cm knee S. @ Chet. S. Scap offload <u>4+ve</u> <u>2+ve</u> slight Cx lat tilt ④
Palpatory Assessment:	
Treatment: NFTT dia costalis longissimus Semi Spinalis, U/T, low Scap.	Advice & Corrective Exercises: Cx Rotn L 60° P. @ U/T R 60° P. @ U/T Cx Lat Flex L 10° P. @ U/T R 10° P. @ U/T
Reassessment & Postural Improvements:	

Next Treatment/Management Plan: as needed

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**

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

Name Linda Hickey

Your signature L M Hickey

Date 7/6/22