Tarrengower Remedial Massage

CLIENT RECORD: Follow-up Consultation

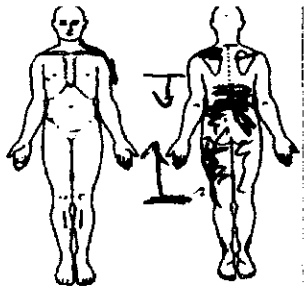
Last Name: MC LEVANT First Name: NEIL. Date 2/7/22

Area Being Treated TX LX H/S ITBS.

Current Presentation LOOTRADIOPS:

Has your Clinical Impression changed? Y (N)
If yes

Response to previous treatment (+'ve, -'veISQ): 4've



Tx
DV
Relief for a couple of days post-treatment
OVT?

Client consent for treatment

Please sign

Date 2/7/22

OBJECTIVE EXAMINATION:

Observation:
Await Ons advice before massaging @ calf.

Palpatory **Assessment:**

Treatment:
MFTT: Ilio costalis, Glute Med Glute Max, H/S. U/T, Lev scap Dip Piriformis, Glute Max Glute Med, Supraspinatus

Reassessment & Postural **Improvements:**

Motion tests (Active, Passive, Resisted, Special Tests):

Advice & Corrective Exercises:
Int & ext Shoulder roth in resistance band

Piriformis Stretch (Seated)

Next Treatment/Management Plan: Next Week

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 coronavirus? **Yes** (**No**)

You are a close contact if you: live in the same house as someone who tests positive. spent 4 hours or longer with someone in a home, or health or aged care environment.

3. Are you waiting on COVID-19 swab results? **Yes** (**No**)
4. Have you been asked to self-isolate by your GP, or a government authority? **Yes** (**No**)
5. 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 Neil MCLEAN

Your signature

Date 2/7/22