Tarrengower Remedial Massage

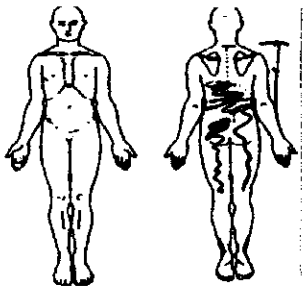
CLIENT RECORD: Follow-up Consultation

Last Name: Mc LEAN First Name: Neil Date 9/7/22

Area Being Treated _____ Current Presentation LOOTRADIOPS:

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

Response to previous treatment (+'ve, -'veISQ): 1 've



Few Days relief after last treatment
Better in mornings

Client consent for treatment

Please sign [signature] Date 9-7-22

OBJECTIVE EXAMINATION:

Observation:

Palpatory **Assessment:**
© calf - sol.d.

Treatment:
MFT

Reassessment & Postural **Improvements:**
SLR L 95° R. (Spring)
R 75° R. (Spring)

Motion tests (Active, Passive, Resisted, Special Tests):
SLR L 85° R. (Spring)
R 60° R. (Spring) &

Advice & Corrective Exercises:
L - Seated Piriformis Stretch
- © leg on seat.
R - Seated H/S Stretch

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 N. McLean

Your signature 

Date 9/7/20