

Tarregower Remedial Massage

CLIENT RECORD: Follow-up Consultation

Last Name: McLENNAN First Name: NEIL

Date 6/8/22

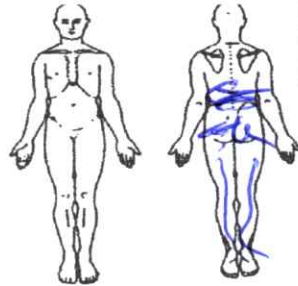
Area Being Treated Lx

Current Presentation LOOTRADIOPS:

Has your Clinical Impression changed? YN

If yes _____

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



Pain returned in lower back / glutes
- Less time spent on LB & glutes due to clearance to work on calves last time

Client consent for treatment

Please sign [Signature]

Date 6-8-22

OBJECTIVE EXAMINATION:

Observation: <u>⇒ Spend more time on LB & Glutes treatment.</u>	Motion tests (Active, Passive, Resisted, Special Tests):
Palpatory Assessment:	
Treatment: <u>MFTT - ESG, TCF, SIS Vertical & Horizontal Slings, lat Dorsi acute red.</u> <u>DIP MRP Acute Max, Piriformis</u> <u>MFTT - HIS, Gastroc.</u>	Advice & Corrective Exercises: <u>Piriformis stretch</u>
Reassessment & Postural Improvements:	

Next Treatment/Management Plan: Next Week (Booked) -

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 6/8/22