Tarrengower Remedial Massage

CLIENT RECORD: Follow-up Consultation

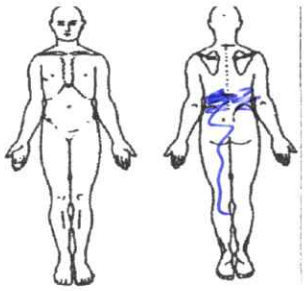
Last Name: McLEAN First Name: NEIL Date 12/8/22

Area Being Treated _____

Current Presentation LOOTRADIOPS:

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

Response to previous treatment (+'ve, -'ve ISQ): 1've
→ 2-3 days relief



QL.

Client consent for treatment

Please sign _____ Date 12-8-22

OBJECTIVE EXAMINATION:

Observation:	Motion tests (Active, Passive, Resisted, Special Tests):
Palpatory **Assessment:**	
Treatment: MFTT QL, Glute Med, Glute Max, H/S, Calves DIP MTrP QL, Glute Med Glute Max	Advice & Corrective Exercises: QL Stretch Piriformis Stretch
Reassessment & Postural **Improvements:**	

Next Treatment/Management Plan: 1 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 12/8/22