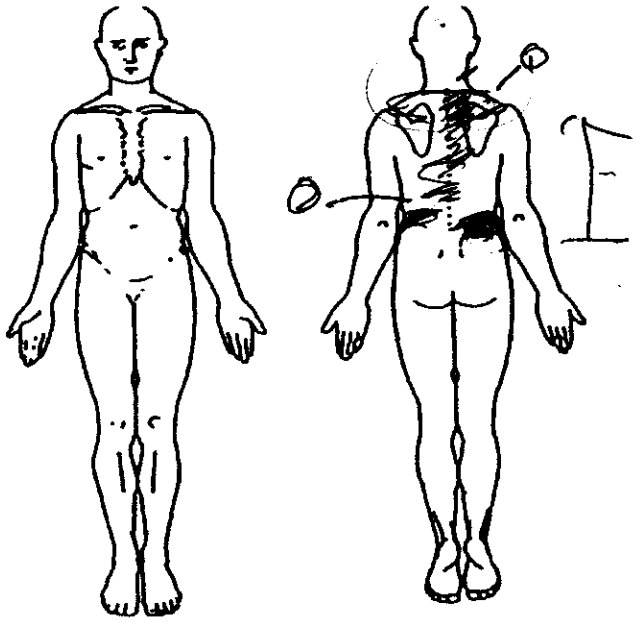
TARRENGOWER REMEDIAL MASSAGE

Date 22/10/24

Initial Consultation Form



Name: David

Indicate site or pain and referral area

Site of restriction

Location of pain/restriction/other: back / shoulders
Ruptured lower disc

Onset - Initial *(when/how it first began)*: ① Acute ② Chronic

Now *(current presentation)*: ① 3-4/10 ② 3-4/10

Other Symptoms:

Type of Pain: Heavy - Sharp in hip if slept

Referral Pain: None indicated

What aggravates the pain? ① Upper body Movement - weave, sort ② Lifting

Degree of Pain (0-10): 6/10 Irritability Level: Low ___ (Med) ① (High) ②

What Offsets / Alleviates the Pain? Walk

Past Treatments & Results: ~~Chir~~ Physio - pretty good but short term

Special Questions *(may also be specific to region)*: Wake @ night?

OBJECTIVE EXAMINATION - **Body Type:** Hypomobile 0-1 (✓) Average 2-4 ( ) Hypermobile 5-9 ( )

Observation

Posterior view	Anterior view	Lateral view
AOA L3-5 R5. SNP ✓ ASIS R↓ pos planus	Head ① rot 10° R Shldr Rot. ASIS R↓	R knee ← no ApT Mal ←

Motion Tests

Active *(P1, S1, PB)*	Passive *[P1, S1, R1)*
Cx Rotn L 60° Pi @ U/T R 60° Pi @ U/T Cx LAT Flex 20° Pi @ ~~Scalenes~~ U/T 15° Pi @ U/T Cx Flex 1 Finger s/a Spinal	
Resisted	**Functional/Special Tests** Trendelenberg +ve Bilat SLR L 45° ↓@ H/S R 50° s.@ H/S Scapula offload. +ve Bilat

Palpatory Assessment:

Clinical Impression: _____

Treatment	Reassessment
MFTT ESG, Glute Med U/T Lev Scap DNP U/T, Lev Scap	Cx Rotn L 60° Pi @ Rest U/T R 70° Pi @ U/T. Cx LAT Flex L 20° Pi @ U/T R 15° Pi @ U/T TX/LX Flex Sens ↓ Knee

Corrective Exercises

Exercise	Sets	Reps	Other Advice
_____	____	____	Seated Lx/Tx Stretch
_____	____	____	_____
_____	____	____	_____

Postural Improvements: _____

Treatment Goals / Management Plan: _____

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 novel 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.

3. Have you returned from overseas within the last 14 days? **Yes** **No**

4. Are you waiting on COVID-19 swab results? **Yes** **No**

5. Have you been asked to self-isolate by your GP, or a government authority? **Yes** **No**

6. Have you received a COVID-19 vaccination in the past 3 days? **Yes** **No**

7. (Clinic only) Have you checked in? **Yes** **No**

8. (Mobile only) How many visitors have been to your house today? N/C

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

Name DAVID BOOTTEN

Your signature

Date 22/10/21

CHECK-IN NOW

Tarrengower Remedial Massage

Unable to scan? Download the Service Victoria app and use code:

QDG Z6Q