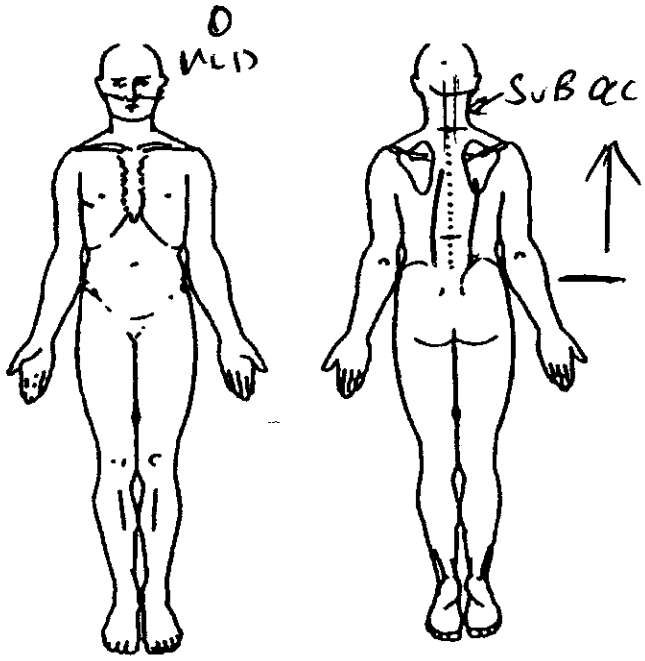
TARRENGOWER REMEDIAL MASSAGE

Date 13/4/22

Initial Consultation Form



Name: Alan Shepherd

Indicate site or pain and referral area

Site of restriction

Location of pain/restriction/other:

MLD - Sinus/ear.

Headaches

-Balance

→ vertigo

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

Now *(current presentation)*: Bilat of pain @ Past ex 7/10

Other Symptoms: Sinus.

Type of Pain: Burning

Referral Pain: None indicated

What aggravates the pain? Sitting

Degree of Pain (0-10): 9/10 Irritability Level: Low_____ Med_____ High

What Offsets / Alleviates the Pain? Work / movement

Past Treatments & Results: Massage

Special Questions *(may also be specific to region)*: Restless Sleeper

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

Observation

Posterior view	Anterior view	Lateral view
ROM ✓ AOC SYL ↳ SCAPS↑	✓	Plumb ✓

Motion Tests

Active *(P1, S1, PB)*	Passive *(P1, S1, R1)*
Resisted	**Functional/Special Tests**
	Scap offload -ve

Palpatory Assessment:

Clinical Impression: _____

_____

Treatment	Reassessment
MFTT ESCs -> U/T MLD -> Head & Neck	

Corrective Exercises

Exercise	Sets	Reps	Other Advice
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____

Postural Improvements: _____

_____

Treatment Goals / Management Plan: 2-weeks - call if needed
lower

_____

Consent for Treatment
I understand that:

- This is a massage treatment and is not a medical or allied health treatment (physiotherapy, osteopathy, chiropractic)
- I have viewed the therapists' qualifications
- The risks specific to my individual circumstances may have a bearing on my decision to proceed with the proposed treatment
- The therapist reviewed my health history before treatment commenced
- The therapist explained that the physical assessment I received may involve partial undressing and may require the therapist to palpate (touch) the area(s) of my body relevant to my presenting condition
- The therapist explained the treatment options to me
- The therapist explained the associated risk and possible side effects with the treatment options as described
- The therapist discussed the massage procedures, the areas of the body to be treated, the undressing and dressing procedures, the draping procedures and the positioning on the table for and during treatment
- The therapist established that the treatment session will be stopped should the treatment as first agreed to, require modification. The therapist will explain the reason for the change and any risks and/or side effects as a result of the change
- I can ask any questions in regard to any modification to the treatment plan. I should be totally comfortable with the explanation and reasoning for the change before consenting to the modification to the initial treatment plan
- The therapist has explained that I have the right to refuse treatment, to make changes to the treatment and to stop the massage at any time
- I have the right to request evidence for treatment that may include the abdomen, anterior and lateral chest, and buttock and / or groin areas. I understand I have the right to refuse treatment of these areas
- If I agree to treatment to any of the areas mentioned in the point above, I may be requested, by the therapist, to complete a consent form relevant to those areas

Only sign below if the above information is understood and has occurred

Client
Name: Alan Shepherd Signature: [signature] Date: 17/4/22

Parent/Guardian
Name:_____ Signature:_____ Date:_____

Therapist
Name: Paul Gilders Signature: [signature] Date: 13/4/22