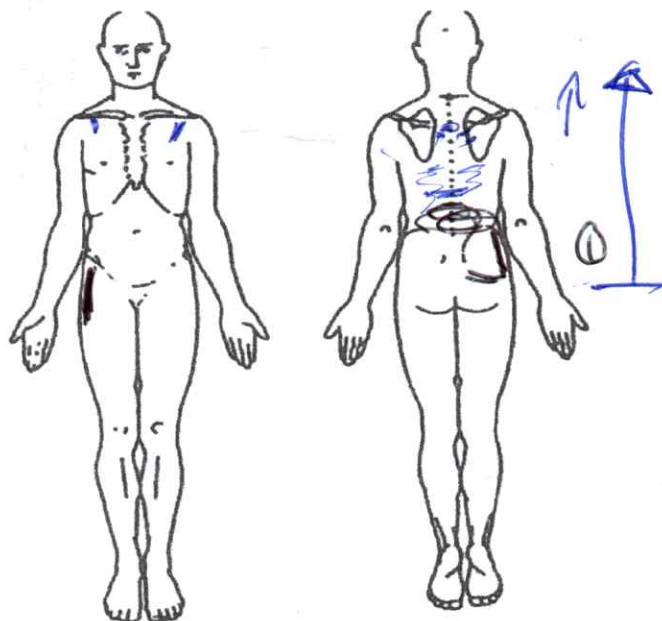


Date 28/4/22

Initial Consultation Form

Name: Fiona Heathcote

Indicate site of pain and referral area

Site of restriction

Location of pain/restriction/other: _____

Lx @ worse
 ① @ HIP
 Piri?
 Koko 7-8 yrs

Onset - Initial (when/how it first began): Few months (acute or chronic)Now (current presentation): not sore sitting (Hip) Lx sore

Other Symptoms: _____

Type of Pain: sharpReferral Pain: ① Post leg @ rightWhat aggravates the pain? external Hip RetnDegree of Pain (0-10): 5-6 Irritability Level: Low Med HighWhat Offsets / Alleviates the Pain? stretchingPast Treatments & Results: Myotherapist 7-8 years ago.Special Questions (may also be specific to region): wake @ night in pain @ HIP
no painkillers

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

Observation

Posterior view SCAPM AOK R2 R3.5	Anterior view subtle int rottn	Lateral view R2 R3 R4 R5 R6 R7 R8 R9 R10 R11 R12 R13 R14 R15 R16 R17 R18 R19 R20 R21 R22 R23 R24 R25 R26 R27 R28 R29 R30 R31 R32 R33 R34 R35 R36 R37 R38 R39 R40 R41 R42 R43 R44 R45 R46 R47 R48 R49 R50 R51 R52 R53 R54 R55 R56 R57 R58 R59 R60 R61 R62 R63 R64 R65 R66 R67 R68 R69 R70 R71 R72 R73 R74 R75 R76 R77 R78 R79 R80 R81 R82 R83 R84 R85 R86 R87 R88 R89 R90 R91 R92 R93 R94 R95 R96 R97 R98 R99 R100 R101 R102 R103 R104 R105 R106 R107 R108 R109 R110 R111 R112 R113 R114 R115 R116 R117 R118 R119 R120 R121 R122 R123 R124 R125 R126 R127 R128 R129 R130 R131 R132 R133 R134 R135 R136 R137 R138 R139 R140 R141 R142 R143 R144 R145 R146 R147 R148 R149 R150 R151 R152 R153 R154 R155 R156 R157 R158 R159 R160 R161 R162 R163 R164 R165 R166 R167 R168 R169 R170 R171 R172 R173 R174 R175 R176 R177 R178 R179 R180 R181 R182 R183 R184 R185 R186 R187 R188 R189 R190 R191 R192 R193 R194 R195 R196 R197 R198 R199 R200 R201 R202 R203 R204 R205 R206 R207 R208 R209 R210 R211 R212 R213 R214 R215 R216 R217 R218 R219 R220 R221 R222 R223 R224 R225 R226 R227 R228 R229 R230 R231 R232 R233 R234 R235 R236 R237 R238 R239 R240 R241 R242 R243 R244 R245 R246 R247 R248 R249 R250 R251 R252 R253 R254 R255 R256 R257 R258 R259 R260 R261 R262 R263 R264 R265 R266 R267 R268 R269 R270 R271 R272 R273 R274 R275 R276 R277 R278 R279 R280 R281 R282 R283 R284 R285 R286 R287 R288 R289 R290 R291 R292 R293 R294 R295 R296 R297 R298 R299 R300 R301 R302 R303 R304 R305 R306 R307 R308 R309 R310 R311 R312 R313 R314 R315 R316 R317 R318 R319 R320 R321 R322 R323 R324 R325 R326 R327 R328 R329 R330 R331 R332 R333 R334 R335 R336 R337 R338 R339 R340 R341 R342 R343 R344 R345 R346 R347 R348 R349 R350 R351 R352 R353 R354 R355 R356 R357 R358 R359 R360 R361 R362 R363 R364 R365 R366 R367 R368 R369 R370 R371 R372 R373 R374 R375 R376 R377 R378 R379 R380 R381 R382 R383 R384 R385 R386 R387 R388 R389 R390 R391 R392 R393 R394 R395 R396 R397 R398 R399 R400 R401 R402 R403 R404 R405 R406 R407 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Motion Tests

<p>Active (P1, S1, PB)</p> <p>Lx Flex Mid Shin 3. @ ESQ</p>	<p>Passive (P1, S1, R1)</p> <p>EX Hip Rotn 40° R. (Spring) Bilat</p> <p>In Hip Rot 30° R. (Spring) Bilat</p> <p>Hip Flex at 125° R. (Spring) Bilat</p>
<p>Resisted</p>	<p>Functional/Special Tests</p> <p>SLR 55° S. @ H/S</p> <p>55° 2 @ H/S</p> <p>Trendelenberg L + ve</p> <p>R - 10</p>

Palpatory Assessment:

Clinical Impression: _____

<p>Treatment</p> <p>MRTT ESQ, U/R, Lev Scarp,</p> <p>Glute Med, Glute Max</p> <p>QL</p> <p>OIP MRP: U/R, Lev Scarp,</p> <p>Glute Med, Glute Max</p>	<p>Reassessment</p> <p>Lx Flex Ankle S. @ ESQ / H/L</p>
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Corrective Exercises

Exercise	Sets	Reps	Other Advice
Cramshells	2	3	Bilaterally
_____	_____	_____	_____
_____	_____	_____	_____

Postural Improvements: _____

Treatment Goals / Management Plan: 2 weeks - re-checked

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: Fiona HEATHCOTE Signature: [Signature] Date: 28/4/22

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

Therapist
Name: Paul Gilders Signature: [Signature] Date: 28/4/22

PATIENT SCREENING QUESTIONNAIRE FOR COVID-19

Please Circle Yes or No

1. Are you fully vaccinated against Covid-19? ☒ Yes ☐ No

a. If no are you booked in for your vaccination or booster? Yes – Date ____/____/____
No

2. 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.

3. Have you been identified as a close contact of a confirmed case of 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.

4. Have you returned from overseas within the last 14 days? ☒ Yes ☐ No

5. Are you waiting on COVID-19 swab results? ☒ Yes ☐ No

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

7. Have you received a COVID-19 vaccination in the past 3 days? ☒ Yes ☐ No

~~8. (Clinic only) Have you checked in? Yes No~~

No longer required

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

Name Fiona Heathcote

Your signature *[Signature]*

Date 28/04/22

CHECK-IN NOW



Tarrengower Remedial Massage



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

QDG Z6Q