

Tarregower Remedial Massage

CLIENT RECORD: Follow-up Consultation

Last Name: HEATHCOTE First Name: FIONA

Date 12/5/22

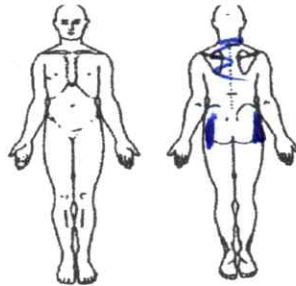
Area Being Treated Glute/cx

Current Presentation LOOTRADIOPS:

Has your Clinical Impression changed? Y N

If yes _____

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



@ Numbers in Foot
Pass

Client consent for treatment

Please sign [Signature]

Date 12/5/22

OBJECTIVE EXAMINATION:

Observation:	Motion tests (Active, Passive, Resisted, Special Tests): <u>FABERS -ve bldat</u> <u>Trendelenberg -ve bldat</u> <u>Obers +ve. bldat</u> <u>Cx Rot L 65° P, @U/T</u> <u>R 70° S, @U/T</u> <u>Cx lat flex L 30° S, @U/T</u> <u>R 20 S, @U/T</u>
Palpatory Assessment:	
Treatment: <u>METT- U/T, Lev Scap, Rhom</u> <u>TLF, Glute Med, Vas lat</u> <u>DIP MTRP - Glute Med, Vas Lat.</u>	Advice & Corrective Exercises: <u>Cx Stretch Bilat</u> <u>Piriformis Stretch</u> <u>clamshells</u> <u>Glute Bridge</u>
Reassessment & Postural Improvements: <u>Cx Rotation L 70° P, @U/T</u> <u>R 80° R @U/T</u>	

Next Treatment/Management Plan: 2 weeks - 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 

Your signature FIONA HEATHCOTE

Date 12 / 5 / 22