Tarrengower Remedial Massage

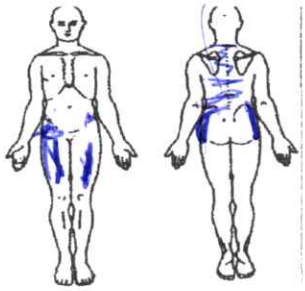
CLIENT RECORD: Follow-up Consultation

Last Name: HEATHCOTE First Name: FIONA Date 4/8/22

Area Being Treated _____

Current Presentation LOOTRADIOPS:

Has your Clinical Impression changed? ~~Y~~ N
If yes ~~N~~



Tx - Tight
Hip - Sore recent
→ recent desk work.

Response to previous treatment (+'ve, -'ve ISQ): TVC

Client consent for treatment

Please sign FA Date 4/8/22

OBJECTIVE EXAMINATION:

Observation:

Palpatory **Assessment:**

Treatment:
MFT LES, RHom, UT
Lev Scap, Splen. cap, Splen Cerv.
Glute Med, Glut Max,
H/S, Calves

Reassessment & Postural **Improvements:**
Hip Flex 125 R(spring)
125 R(springs)

Motion tests (Active, Passive, Resisted, Special Tests):
Hip Flex L 100 R(Spring)
R 95 R(Springs)

Advice & Corrective Exercises:
Continue previous
Stretches
Slowly ↑ walk dist.

Next Treatment/Management Plan: 3 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 FIONA HEATHCOTE

Your signature F H

Date 04 / 08 / 22