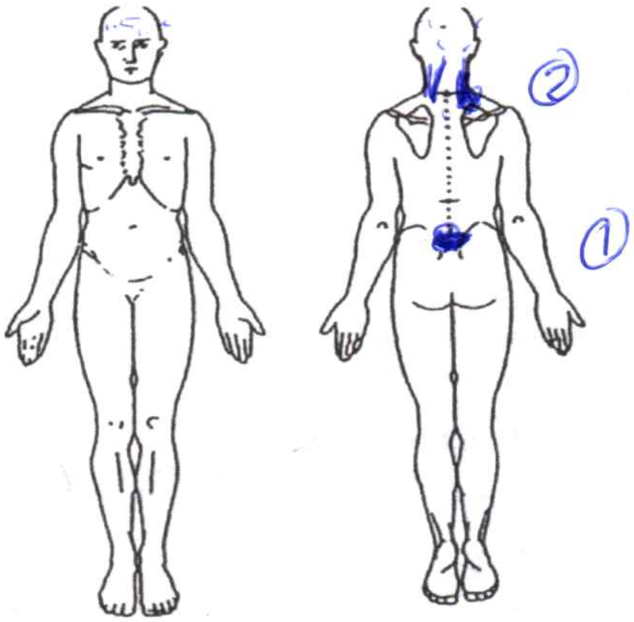
TARRENGOWER REMEDIAL MASSAGE

Date 4/5/22

Initial Consultation Form

Name: Hayley Addlem



Indicate site or pain and referral area

Site of restriction

Location of pain/restriction/other:

① S.I.J ? dysfunction

② cx U/T active MTrP.

Onset - Initial *(when/how it first began)*: ① 3/7 ago - rapid onset in AM

Now *(current presentation)*: 4/10

Other Symptoms: Standing tall to relieve pain in LB

Type of Pain: ache → sharp

Referral Pain: None indicated

What aggravates the pain? Twisting, Slump

Degree of Pain (0-10): 8 Irritability Level: Low —— (Med) —— High

What Offsets / Alleviates the Pain? Standing tall, heat, some stretch

Past Treatments & Results: ① Osteo after last childbirth } +'ve
② Osteo / Massage

Special Questions *(may also be specific to region)*: sleep? for 20days

11
00
11
0

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

Observation

Posterior view	Anterior view	Lateral view
SCAL L ↗ RL AOGC ↑ R 3.5	CLAV CL ✓ ARIS ✓ Shldr IR Rot R	APT 1.0 PLUMB L ✓ R ✓

Motion Tests

Active *(P1, S1, PB)*	Passive *[P1, S1, R1)*
Lx Flex Knee S, @ TLF Cx Flex 2fingers S, @ Splen Cap. Lat Flex L 20° S @ U/T R 20° P, @ Splen Cap Roth L 45° P, @ Lev Scap R 50° P, @ Lev Scap C	
Resisted	Functional/Special Tests Slump -ve Trendelenburg -ve Scap offload +'ve Bilat. SLR L 60° P, (spring) R 85 R, spring

Palpatory Assessment: Cx - splenius capitus Hypertonic & tender.

Clinical Impression: SIJ Dysfunction / Cx Limited ROM due to ~~the~~ carrying 1 y/o daughter

Treatment	Reassessment
MFTT ESG, U/T, Lev Scap, Splen Cap. Supraspinatus D, P MT, P Lev Scap, Supra, U/T	Cx Roth L 60° P, @ Lev Scap R 60° P, @ Lev Scap. Cx Lat Flex L 30° S, @ U/T R 30° S, @ U/T

Corrective Exercises

Exercise	Sets	Reps	Other Advice
Cx Stretch	2	1	(LAT Stretch)
Pec Minor Str			
Lx Stretch			

Postural Improvements:

Treatment Goals / Management Plan: Check back next week & call if req'd.

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: Hayley Addlem Signature: H Addlem Date: 4/5/22

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

Therapist
Name: Paul Gilders Signature: P. Gilders Date: 4/5/22

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**

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

Name Hayley Addlem

Your signature HAddlem

Date 4/5/22