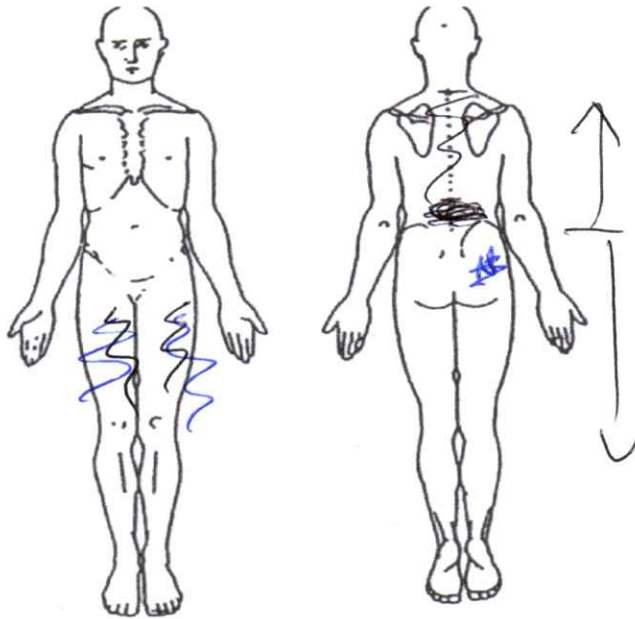


Name: Anne-Marée
McLomp

Indicate site of pain and referral area

Site of restriction

Location of pain/restriction/other: _____

coxa?PiriformR leg - bandingOnset - Initial (when/how it first began): Chronic / Acute on chronic 2-3/12

Now (current presentation): _____

Other Symptoms: 1Type of Pain: Tightness / stiffnessReferral Pain: → ↓ leg (Piriform Synd) sciatic nerve?What aggravates the pain? Sitting, sleepingDegree of Pain (0-10): 4-8 Irritability Level: Low _____ Med _____ HighWhat Offsets / Alleviates the Pain? movement / stretchingPast Treatments & Results: massageSpecial Questions (may also be specific to region): Morning - can't bend leg - lower back
Doesn't**OBJECTIVE EXAMINATION** - Body Type: Hypomobile 0-1 () Average 2-4 (✓) Hypermobile 5-9 ()**Observation**

Posterior view R Spld ✓ Pgs ✓ Pos Anas R/L AOC 4.5/4	Anterior view ACT R ↑ ASIS R ↑ CLUL R ↑ Shld's Int rot.	Lateral view Plumb GT → (R) APT (R) 2.0 Q 1.5
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Motion Tests

Active (P1, S1, PB) Lx/Rx Flex Floor s.c. calf- CP ext 2 fingers	Passive (P1, S1, R1) HIP Flexion
Resisted	Functional/Special Tests SLR @ 80° s.c. Pop loss THOMAS 12 60° s.c. H/S Obers +ve R 5 finger +ve L

Palpatory Assessment:

Clinical Impression: _____

Treatment METTS ESG, Rec Fem, J/T, Low Scap, Ant Max AP MTP Low Scap, Supra Pin & stretch Rec Fem Piri (Bilat)	Reassessment
--	---------------------

Corrective Exercises

Exercise	Sets	Reps	Other Advice
_____	1	3	Piri Stretch
_____	_____	_____	_____
_____	_____	_____	_____

Postural Improvements: _____

Treatment Goals / Management Plan: _____

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: Anne + Maree McGibb Signature:  Date: 1/12/21

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

Therapist
Name: Paul Gilders Signature:  Date: 1/12/21

PATIENT SCREENING QUESTIONNAIRE FOR COVID-19

Please Circle Yes or No

1. Have you received both Covid Vaccinations? **Yes** No
a. If no are you booked in for your vaccination? **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.

3. Have you returned from overseas within the last 14 days? **Yes** **No**
4. Are you waiting on COVID-19 swab results? **Yes** **No**
5. Have you been asked to self-isolate by your GP, or a government authority? **Yes** **No**
6. Have you received a COVID-19 vaccination in the past 3 days? **Yes** **No**
7. (Clinic only) Have you checked in? **Yes** **No**
- ~~8. (Mobile only) How many visitors have been to your house today? ____~~

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

Name Anne-Maree McGonb

Your signature 

Date 1 / 12 / 21

CHECK-IN NOW



Tarregower Remedial Massage



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

QDG Z6Q