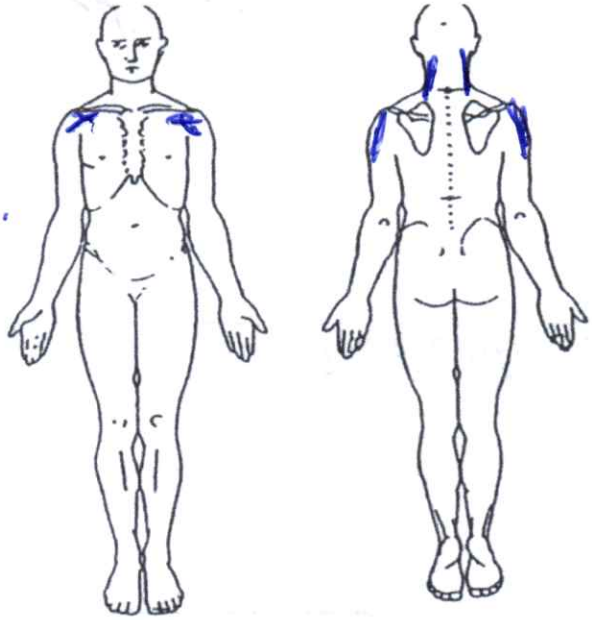
TARRENGOWER REMEDIAL MASSAGE

Date 11/5/23

Initial Consultation Form

Name: Bill McKnight (8840)



Indicate site or pain and referral area

Site of restriction

Location of pain/restriction/other:

Cx
Pecs, Supra, Delts

Onset - Initial *(when/how it first began)*: 6-8 months

Now *(current presentation)*: Restricted.

Other Symptoms:

Type of Pain:

Referral Pain: None

What aggravates the pain? Washing

Degree of Pain (0-10): 5-6 Irritability Level: Low ____ Med ____ High

What Offsets / Alleviates the Pain? Rest

Past Treatments & Results: NIL

Special Questions *(may also be specific to region)*: ~~No~~ Weaker after ~~night~~ restrictions

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

Observation

Posterior view	Anterior view	Lateral view
Scap ✓ Post ✓	Shldrs Int Rot.	L Shldrs Int Rot

Motion Tests

Active (P1, S1, PB)	Passive (P1, S1, R1)
Cx Rotn L 45° S, @ U/T R 45° S @ U/T Lat Flex L 40° S @ U/T R 30° P. @ Sm	Shldr abd L 90° PR R 90° PR
Resisted	**Functional/Special Tests** Scap dyskin L - Cx R - Cx.

Palpatory Assessment:

Clinical Impression: _____

Treatment	Reassessment
MFT/ Ilio costalis, Longissimus, Semispinalis, U/T, Lev Scap, Lat Dorsi, Rec Maj Rec Min DIP MT, P Lev Scap, U/T	Shldr abd L 120° PB R 120° PB Cx Rotn L 60° S, @ U/T R 60° S, @ U/T

Corrective Exercises

Exercise	Sets	Reps	Other Advice
			Cx Stretch.

Postural Improvements: _____

Treatment Goals / Management Plan: DNA Needed