Tarrengower Remedial Massage

CLIENT RECORD: Follow-up Consultation

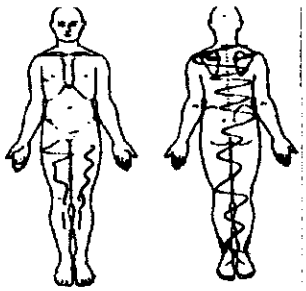
Last Name: PETRUSMA First Name: KATIE Date 30/7/22

Area Being Treated Whole

Current Presentation LOOTRADIOPS:

Has your Clinical Impression changed? (Y)N
If yes Tightness due to football

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



Generally Sore all over
→ Started to play football

Client consent for treatment

Please sign

Date 30/7/22

OBJECTIVE EXAMINATION:

Observation:	Motion tests (Active, Passive, Resisted, Special Tests):
Palpatory **Assessment:**	
Treatment: MFT ESC, U/T, Lev Scap, sub occ. ptals, Glute Med Glute Max, H/S calf, Rec Fem	Advice & Corrective Exercises: calf raises Quad Stretch Piriformis Stretch
Reassessment & Postural **Improvements:** P&S Rec Fem O.P MT, P U/T.	

Next Treatment/Management Plan: Call when needed.

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 Katie Petrusm

Your signature

Date 30 / 7 / 22