Tarrengower Remedial Massage

CLIENT RECORD: Follow-up Consultation

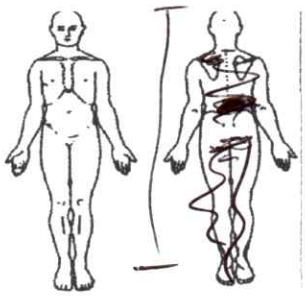
Last Name: Petrusma First Name: Donna Date 12/5/22

Area Being Treated _____

Current Presentation LOOTRADIOPS:

Has your Clinical Impression changed? Y (N)
If yes _____

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



Post IM treatment

Client consent for treatment

Please sign Donna Petrusma. Date

OBJECTIVE EXAMINATION:

Observation:	Motion tests (Active, Passive, Resisted, Special Tests): FABERES +ve bilat Gaeslens -ve bilat
Palpatory **Assessment:**	
Treatment: MFR: TLF, ESL, U/T, Lat Scap H/S Gastroc, Plantar Fascia QLP Glute Med, U/T, Lat Scap P&S Piriformis bilat	Advice & Corrective Exercises: Piriformis Stretch Lower back Stretch (Leg over)
Reassessment & Postural **Improvements:**	

Next Treatment/Management Plan: As 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 Donna Petrusma

Your signature Donna Petrusma

Date 15 / 5 / 22