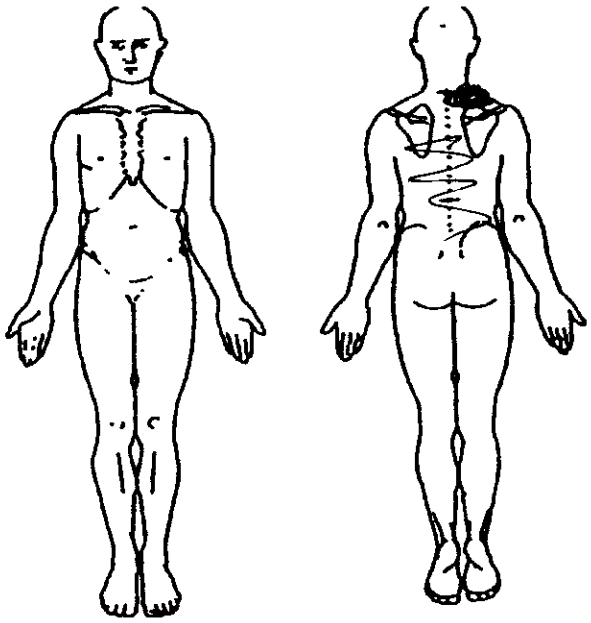
TARRENGOWER REMEDIAL MASSAGE

Date 24/2/22
Initial Consultation Form

Name: Kirk Wagstaff



Indicate site or pain and referral area

Site of restriction

Location of pain/restriction/other: (R) C6

Onset - Initial *(when/how it first began)*: 1/12

Now *(current presentation)*: 4-5

Other Symptoms: Headache

Type of Pain: Sharp

Referral Pain: Headaches only

What aggravates the pain? Physical

Degree of Pain (0-10): 8-9. Irritability Level: Low ~~Med~~ (Med) High

What Offsets / Alleviates the Pain? Tiger Balm

Past Treatments & Results: None

Special Questions *(may also be specific to region)*: Worse in evening

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

Observation

Posterior view	Anterior view	Lateral view
R Scap↑ AoC = 3.5 2 3.5R PSIS ✓ Pes Planus.	clvcl ✓ ASIS ✓ AcR ✓ Shld rotn ✓	Plumb R LM← APT = 1.0 L LM←

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Motion Tests

Active *(P1, S1, PB)*	Passive *[P1, S1, R1)*
Shld ABD (L) 175° P1 @ LevScap (R) 160° P1 @ LevScap Shld Flex L 120° PB R 180° PB Cx Rotn L 80° P1 @ U/T 80° P1 @ U/T Cx Lat	
Resisted	**Functional/Special Tests**

Palpatory Assessment:

Clinical Impression: _____

Treatment	Reassessment
MFTT: ESC, U/T, & LevScap, Post Scalene DIP MTrP: Lev Scap, U/T, Rhom, Mid. Trap	Shld ABD (L) 180° P1 @ LevScap (R) 180° P1 @ LevScap

Corrective Exercises

Exercise	Sets	Reps	Other Advice
_____	~~5~~	~~3~~	U/T Stretch x5 Blat
_____	1->3	5	_____
_____	____	____	_____

Postural Improvements: _____

Treatment Goals / Management Plan: Do exercises, book when needed.

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)
8. (Clinic only) Have you checked in? (Yes) **No**

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

Name KIRK WOJNIUSZ

Your signature

Date 24/2/22

CHECK-IN NOW

Tarrengower Remedial Massage

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

QDG Z6Q