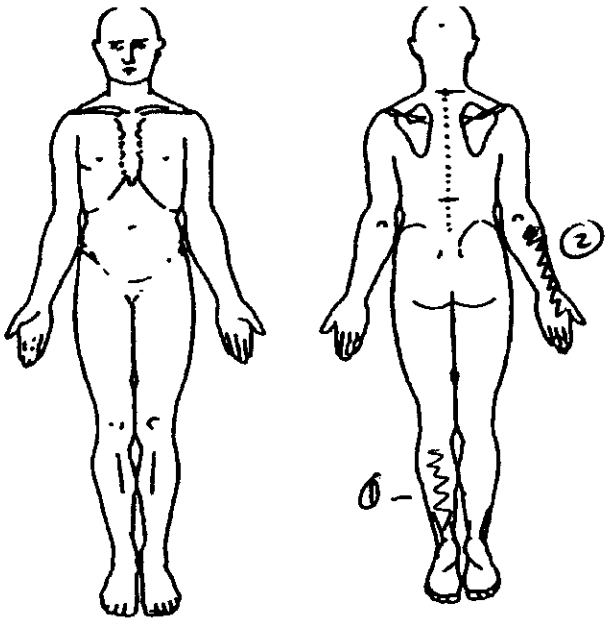
TARRENGOWER REMEDIAL MASSAGE

Date 12/1/22
Initial Consultation Form

Name: Craig Adams.



Indicate site or pain and referral area

Site of restriction

Location of pain/restriction/other:

① ⓛ calf - strain?

ⓛ Ankle/foot fracture 4/21

② r Forearm Extensor tendinopathy?
Median nerve pain ®?

(2) 12/21.

Onset - Initial *(when/how it first began)*: ① sudden. Splitting wood, gardening.

Now *(current presentation)*: 7/10

Other Symptoms:

Type of Pain: stinging in elbow.

Referral Pain: Wrist → Fingers

What aggravates the pain? using arm - picking up (extension)

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

What Offsets / Alleviates the Pain? rest, heat

Past Treatments & Results: none

Special Questions *(may also be specific to region)*: wake at night? N

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

Observation

Posterior view	Anterior view	Lateral view
ROM 3.0 L 3.1 R Ecch ✓ Rs ✓ ⓛ Hip IR	Protracted Shlders IR Shld.	Kyphosis ✓ Plumb ↑ Knee ← Mal ←

Motion Tests

Active *(P1, S1, PB)*	Passive *(P1, S1, R1)*
~~R Wrist Ulna Dev 3~~ R Wrist ext 90° PB Flex 90° PB	R Wrist Ulna dev 35° R. (block)
Resisted	**Functional/Special Tests** 3rd Finger ext. @ -ve

Palpatory Assessment:

Clinical Impression: _____

Treatment	Reassessment
MFR ECRL, ECRB, Pron. Teres DiP ECRL.	

Corrective Exercises

Exercise	Sets	Reps	Other Advice
_____	2	10	Extensor Stretch x2 daily.
_____	5	10	eccentric Extensor Stretch w weight x2 daily.
_____	___	___	_____

Postural Improvements: _____

Treatment Goals / Management Plan: Referral → Sonny for Fluid in D leg. Evang to reassess @ Forearm in 2/52.

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 Craig Adams

Your signature Craig Adams

Date 12/1/22

CHECK-IN NOW

Tarrengower Remedial Massage

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

QDG Z6Q