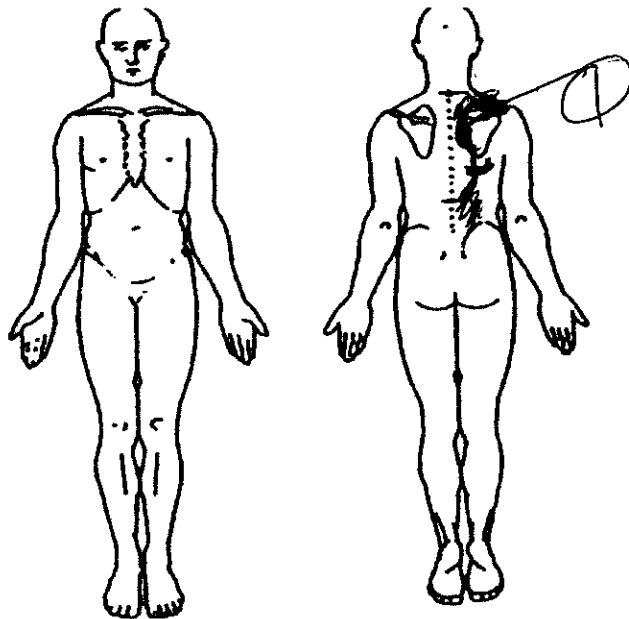


Genevieve Ladds



Indicate site of pain and referral area

Site of restriction

Location of pain/restriction/other: \_\_\_\_\_

Rhomboid

ESQ

Onset - Initial (when/how it first began): Over last 10 daysNow (current presentation): Dull ache

Other Symptoms: \_\_\_\_\_

Type of Pain: Dull acheReferral Pain: None indicatedWhat aggravates the pain? sitting for too longDegree of Pain (0-10): \_\_\_\_\_ Irritability Level: Low (Med) HighWhat Offsets / Alleviates the Pain? lying down / restPast Treatments & Results: Not specifically  
massage / chiro / osteo worked in pastSpecial Questions (may also be specific to region): no waking

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

Observation

Posterior view  
R Scapula

AOC 4

Anterior view

R ACFT  
sticks in Rot

Lateral view

APT  
NO FHC  
R ACFT
 1  
00  
00  
11

# Motion Tests

<p>Active (P1, S1, PB)</p> <p>Cx Rotn L 45 PB  R 45 PB  Lat Flex L 45° 81 @ U/T  R 45° 119 @ U/T  Cx Flex 2 Fingers PB  3 @ Longiss</p>	<p>Passive (P1, S1, R1)</p>
<p>Resisted</p>	<p>Functional/Special Tests</p> <p>SLR. L 90 PB  R 90 PB</p>

Palpatory Assessment:

Clinical Impression: Tight ES9, U/T Low Scap

<p>Treatment</p> <p>MFTT &amp; DIP ES9 U/T  RACMB Low Scap</p>	<p>Reassessment</p> <p>Cx Rotn 55° PB  R Rotn 60° PB  Cx Flex 2 Fingers PB</p>
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## Corrective Exercises

Exercise	Sets	Reps	Other Advice

Postural Improvements:

Treatment Goals / Management Plan:

## 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 novel 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.

3. Have you returned from overseas within the last 14 days? Yes ☒ No

4. Are you waiting on COVID-19 swab results? Yes ☒ No

5. Have you been asked to self-isolate by your GP, or a government authority? Yes ☒ No

6. Have you received a COVID-19 vaccination in the past 3 days? Yes ☒ No

7. Clinic only) Have you checked in? ☒ Yes ☐ No

8. (Mobile only) How many visitors have been to your house today? \_\_\_\_

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

Name Genevieve Ladds

Your signature G Ladds

Date 17/8/2021

**CHECK-IN NOW**



Tarregower Remedial Massage



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

**QDG Z6Q**