



**Excelsior**  
**SPORTS THERAPY**

Move better. Perform better.

# Health History Form

Please complete this form as best as you can. Please print clearly.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Post Code: \_\_\_\_\_

Email: \_\_\_\_\_ Mobile: \_\_\_\_\_

Occupation: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Recreational activities: \_\_\_\_\_

Contact name and telephone number in case of emergency: \_\_\_\_\_

How did you hear about us: \_\_\_\_\_

Please tick (✓) all conditions that apply now. Put a **P** for past conditions.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart, circulatory problems | <input type="checkbox"/> Cancer/tumours                  | <input type="checkbox"/> Fatigue                                |
| <input type="checkbox"/> High/low blood pressure     | <input type="checkbox"/> Asthma or lung conditions       | <input type="checkbox"/> Depression                             |
| <input type="checkbox"/> Varicose veins              | <input type="checkbox"/> Hernias                         | <input type="checkbox"/> Seizures                               |
| <input type="checkbox"/> Blood clots                 | <input type="checkbox"/> Abdominal or digestive problems | <input type="checkbox"/> Stroke                                 |
| <input type="checkbox"/> Infectious disease          | <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> Skin disorders                         |
| <input type="checkbox"/> Allergies                   | <input type="checkbox"/> Numbness or tingling            | <input type="checkbox"/> Previous motor vehicle accident/trauma |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Muscle, bone injuries           | <input type="checkbox"/> Headaches or migraines                 |
| <input type="checkbox"/> Pregnancy                   | <input type="checkbox"/> Muscle or joint pain            | <input type="checkbox"/> Prosthesis or dentures                 |
| <input type="checkbox"/> Accident/trauma             | <input type="checkbox"/> Chronic pain                    | <input type="checkbox"/> Other (please specify below)           |

Other medical conditions or injuries not listed (past and present): \_\_\_\_\_

Current medications, including aspirin, ibuprofen, herbs, vitamins, etc: \_\_\_\_\_

Recent surgeries (past 5 years): \_\_\_\_\_

In accordance with the scope of practice of a myotherapist as well as adhering to regulatory and statutory requirements it is not the role of the therapist to diagnose injury or illness, or prescribe medication. The therapist will explain the treatment before commencing, the client has the right to refuse any part of the treatment at any time.

If indicated treatment may include dry needling. The risks of dry needling include bleeding, bruising, pain and pneumothorax\* (\*only if needling around the thoracic region). All needling will be performed within the scope of practice of a myotherapist. Dry needling policy available at [www.excelsiorsports.com.au](http://www.excelsiorsports.com.au)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Privacy Policy



All information is kept in accordance to the Australian Privacy Principles and the National Privacy Act.

## Collection of your Personal Information

In order to provide better service to our valued customers, we may request personal details such as your name, address, telephone number or e-mail address. If you choose to withhold requested personal information, we may not be able to provide you with the customer service you require should that depend on the collection of that information, particularly if the collection of that information is required by law.

## Use of your Personal Information

The personal information that we seek is generally used for the purpose of being of service to you. We do not use your personal information for any purpose other than for the purpose for which it was disclosed. You have the right to request that we stop contacting you at any time.

## Disclosure of your Personal Information

We do not provide or sell your personal information to other organisations. We may discuss your treatments and conditions with other medical professionals if it will benefit your overall outcome. This will not be done without your consent and permission.

## Storage and Security of your Personal Information

We take measures to ensure your personal information is protected from unauthorised access, loss, misuse, disclosure or alteration. Your personal information is stored in a secure location and only accessible by those required to access it. In accordance to Australian Privacy Principles all records will be kept for a period of 7 years. We also take measures to remove your personal information when it is no longer required for the purpose for which it was collected.

## Access to Your Personal Information

We take all reasonable steps to ensure that personal information that we hold about you is as accurate as is possible. We will always provide you with access to any personal information we hold about you. You are able to contact us at any time and ask for its correction if you feel the information we have about you is inaccurate, incomplete or out of date.

Before we provide you with access to your personal information, we will require some proof of identity. We do this to protect the confidentiality of your personal information.

I have read the above information and understand that my personal information will be kept in accordance to this privacy policy.

**Signature:**

**Date:**