MELBOURNE SPORTS & ALLIED HEALTH CLINIC

Registration & Health History

Surname: .....Title: ☐ Mr, ☐ Mrs, ☐ Miss, ☐ Ms, ☐ Dr

Given Name (s): .....Date of Birth:.....

Home Address: .....

Email:.....

Phone (Home): .....Work.....Mobile: .....

Medical Doctor (name/address/phone):.....

.....

Private medical cover provider:.....Medicare #:.....

Who recommended this clinic to you, or how did you find us?.....

Have you ever had any of the following?	NO	YES		NO	YES	**Family history:** NO	YES	**Relationship?**
Rheumatic Fever	☐	☐	Diabetes	☐	☐	☐	☐	_____
Epilepsy	☐	☐	High Blood Pressure	☐	☐	☐	☐	_____
Asthma	☐	☐	Heart attack	☐	☐	☐	☐	_____
Tuberculosis	☐	☐	Pacemaker Implants	☐	☐	☐	☐	_____
Hepatitis	☐	☐	Congenital heart disease	☐	☐	☐	☐	_____
Kidney Disease	☐	☐	Excessive Bleeding	☐	☐	☐	☐	_____
Lymphodemia	☐	☐	Stroke	☐	☐	☐	☐	_____
Skin Lesions	☐	☐	Angina	☐	☐	☐	☐	_____
AIDS / HIV	☐	☐	Disease of blood vessels	☐	☐	☐	☐	_____
Lung disease	☐	☐	Heart rhythm condition	☐	☐	☐	☐	_____
Back injury	☐	☐	Cancer	☐	☐	☐	☐	_____
Surgery	☐	☐	High cholesterol/trigs	☐	☐	☐	☐	_____

If "yes" or other, please describe:.....

.....

Have you ever had any problems with medical treatment?	☐	☐	
Female patients, are you pregnant?	☐	☐	
Do you smoke?	☐	☐	_____
Are you allergic to anything, including medications?	☐	☐	_____

List any medication you are presently taking:.....

.....

Symptoms during or following exercise:	NO	YES
Severe shortness of breath or difficult breathing	☐	☐
Pain in chest, back, arm, jaw or racing heart rate	☐	☐
Leg pain during mild physical activity	☐	☐
Dizziness, nausea, fainting	☐	☐
Severe heat exhaustion (heat stroke)	☐	☐

Terms & Conditions:

1. Consultation fees are required to be settled in full on the same day.
2. Failure to attend your scheduled appointment will incur a cancelation fee of 100%.
3. Cancelations within 24hrs of scheduled appointment will incur a cancelation fee of 50%.
4. Patients/clients under the age of 18 years require the presence of a parent or guardian during consultation, unless prior consent is provided.

Privacy Statement

MSAHC complies with all applicable Commonwealth and Victorian privacy legislation relating to the collection, use, disclosure and handling of your personal and health information. Relevant legislation includes the *Privacy Act,* the *Health Records Act* and the *Information Privacy Act*.

Wherever possible, we will obtain personal and health information from you.
MSAHC will use the personal and health information collected about you for the following purposes

- Assessing your health;
- Determining which health assessments meet your physical needs;
- Adapting our services to suit your personal needs; and
- Planning and managing MSAHC.

If we cannot obtain your personal or health information, we may be unable to fully cater to your health or other personal requirements.

The information you give to MSAHC is kept confidential. We may disclose your information to agents or contractors we engage but only for the purposes set out above. We may also disclose personal and health information to the Department of Health and Ageing, health care practitioners, or any person or organisation authorised by you or by law to obtain it.

If we disclose your information for any of the above reasons to any other person or organisation, we will create a written record of the date of disclosure, the information disclosed, the person or institution to whom the disclosure was made and the reason why we disclosed your information.

MSAHC may keep your personal and health information in electronic or paper form. MSAHC will keep the information secure to ensure there is no unauthorised use or disclosure. MSAHC makes all reasonable efforts to ensure that your information is accurate, complete and up to date. MSAHC will keep data for at least seven years after you cease to receive care from us, or otherwise as required by law.

You may at any time request in writing access to the information stored about you. We will respond to such a request within 45 days. If we decide not to provide you or with access to information we will provide you with written reasons for our decision.

If you believe that the information MSAHC holds about you is inaccurate, incomplete, misleading or not up to date, you may request in writing that the information be corrected. We will respond to a request to amend information within 45 days. If we decide not to correct the information we will provide you with written reasons for our decision.

Declaration

I declare that the information provided by myself is to the best of my knowledge true and correct, and that I have not omitted any information requested. Whilst there is no obligation to provide information requested of me, I do understand that failure to provide said information may impair the quality of treatment that I receive.
I have read and understand the terms and conditions, and privacy statement detailed within this document.

Signed:_____ **Date:**_____