

# Flynn Perez

**DOB** 25 Aug 2001  
**Occupation** Elite Athlete - football  
**Medicare No.** GMHBA  
**Practitioner** Kevin Skillen

## Patient Forms

### Initial History and Consent Form

**Practitioner:** Kevin Skillen  
**Appointment:** 19 May 2021, 4:00PM  
**Completed:** 19 May 2021, 2:58PM

### Privacy Policy:

In order to identify and contact you, as well as provide you with the best possible treatment outcome, we must collect some of your personal information such as name, phone number, address, etc as well as medical and health information. We take the utmost care to ensure it is protected against misuse, loss, interference, unauthorised access, modification and disclosure.

**Acceptance** ☒ I accept the above Privacy Policy

### Client Details

**First Name** Flynn

**Last Name** Perez

**Preferred Name**

**Address** 1/98 Westbury street

**Date of Birth** 25/08/2001

**Preferred Phone Number if we need to contact you** 0411267740

**Please provide the name and phone number of your emergency contact**

**Your Occupation** Athlete

**How were you referred to us?** ☐ Website ☐ Passing by ☐ NDIS ☐ Carers Victoria  
☐ Medical or allied health professional ☒ Friend/family

**If you were referred by a medical or health professional, or friend or family please tell us who.** NMFC

**Covid-19 (if you answer yes to any of Covid-19 questions please call us on 9078 9185 prior to your appointment)**

Do you have, or have you recently suffered ☐ Yes ☒ No  
symptoms such as fever, runny nose,  
cough, sore throat or headaches?

Have you travelled to a designated Covid-  
19 Hotspot within the last 14 days? ☐ Yes ☒ No

Have you been in contact with any person ☐ Yes ☒ No  
known to be a positive Covid-19 case  
within the last 14 days?

Have you received a Covid-19 Vaccination ☐ Yes ☒ No  
within 20 days prior to your appointment  
date?

### General Medical and Lifestyle:

Have you ever had Covid-19? ☐ Yes ☒ No

Are you, or do you suffer from any of the following (if yes, please check box) ☐ Heart disease or disorder ☐ AIDS, HIV ☐ Asthma  
☐ High blood pressure ☐ Low blood pressure  
☐ Numbness or pins and needles ☐ Headaches or migraines ☐ Hepatitis ☐ Pregnant ☐ Poor circulation  
☐ Epilepsy ☐ Osteoporosis ☐ Type 1 Diabetic ☐ Type 2 Diabetic ☐ Endometriosis ☐ Arthritis  
☐ Mental illness

Please list any neck or spinal injuries you  
have had and approximate dates

Please list any surgeries you have had and approximate dates ACL MARCH

Please detail any cancer you have had,  
approximate diagnosis date and  
treatment provided or undergoing

Please list any infectious disease you have

Please list any allergies you have

Please enter the name and phone number  
of your doctor

What are your current medications?

Please check any health conditions in your immediate family ☐ Heart Disease ☐ Stroke ☐ Diabetes ☐ Arthritis  
☐ High or Low Blood Pressure ☐ Neurological Disorder ☐ Obesity  
☐ Cancer

What recreational activities do you do  
each week?

What is the reason for your visit?

Please list any areas of your body you DO

**NOT want us to treat****Is there anything else you would like to us  
to know to help treat you better?****Cancellation Policy:**

If you wish to cancel an appointment, we require at least 12 hours notice of cancellation. If an appointment is cancelled less than 12 hours before the scheduled appointment time, you may be charged a fee. Missed appointments without notification may also incur a fee.

**Acceptance**☒ I accept the above cancellation policy**Consent:**

Seddon Therapies agrees to provide you with a professional Remedial/Myotherapy treatment tailored to your individual needs with qualified and fully insured therapists. Confidentiality is respected and at no time is any information received from the client during the treatment given to any other person, except with the express permission of the client. Electronic records of treatment and appointments are kept on Cliniko, operated by a third party provider. Their Privacy Policy can be viewed at <https://cliniko.com/policies/privacy>. You as our client, agree that all the information that you have supplied is true and correct to the best of your knowledge. Failure to disclose information about your health history may affect the treatment you are given. We cannot be held responsible for any effect our treatment has on an existing condition if you have not disclosed it to us here. Likewise, if you develop a new health condition whilst you are a client of Seddon Therapies, you must advise us of any changes to your health history.

Remedial Massage and Myotherapy is a non-invasive treatment for soft tissue dysfunction. It does not usually have any side effects but we would like to advise that post treatment, you may feel a little sore which is quite common and normal. The discomfort you feel post treatment will be similar to the discomfort you can feel post exercise and should ease up within a few days after your treatment. If you have any concerns about how you feel after your treatment with us, please contact us immediately for assistance.

Underwear is always to be worn during treatments and you will be draped with towels appropriately to respect your privacy unless you have expressly been requested to remove underwear for best treatment results. Your express permission will be sought prior to each occasion this is seen as beneficial.

At any time during your treatment, if you are uncomfortable, you have the right to speak up and ask your therapist to stop doing a particular technique. You are also able to stop the massage at any point if you wish to.

**Acceptance**☒ I have read the agreement for care and accept these terms and conditions**Please insert your electronic signature or  
type your full name in the space provided**

Flynn perez

**Please insert the date**

19/05