



**HEALTH ASSESSMENT FORM FOR PHYSICIANS**  
Intake Requirement for Okanagan Valley College of Massage Therapy Ltd.

**Date:** \_\_\_\_\_ **Patient's Name:** \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_ **Clinic Name:** \_\_\_\_\_  
Please Print Please Print

**Physician:**

This form is to be completed as part of the requirements for admission to the Okanagan Valley College of Massage Therapy. The nature of the course work and intense intimate setting requires good health and emotional stability. At the conclusion of the program graduates are eligible to write board exams to qualify as Registered Massage Therapists. **This information will be kept confidential.**

How long have you known this individual as a patient? \_\_\_\_\_

Does this individual have a history of mental or physical health issues? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_  
If yes, please indicate diagnosed conditions and status of treatment.

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Has this individual sustained any injury that requires ongoing treatment? Please give details.

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Overall health level: Excellent \_\_\_\_\_ Very Good \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Is there other health concerns that you feel might get in the way of this individual's success in the program?

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\_\_\_\_\_  
**Physician's Signature**

**Applicant:** I hereby give permission for this information to be released as part of the application to the massage therapy program at OVCMT.

\_\_\_\_\_  
**Applicant's Name (Please Print)**

\_\_\_\_\_  
**Applicant's Signature**