



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 three-year program of massage therapy education. 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.

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

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?

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