HEALTH ASSESSMENT FORM FOR PHYSICIANS

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 on-going participation in the Massage Therapy Program at the Okanagan Valley College of Massage Therapy. The nature of the course work and intense intimate setting requires good health and emotional stability.
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 or chronic condition that requires ongoing treatment? Please give details.

Overall health level: Excellent _____ Very Good _____ Good _____ Fair _____ Poor _____

Is this individual medically fit to <u>fully</u> participate in the practical portion of the program?

_____
Physician's Signature

Applicant: I hereby give permission for this information to be released as part of my on-going participation in the massage therapy program at OVCMT.

_____ _____
Applicant's Name (Please Print) **Applicant's Signature**