Okanagan Valley College of Massage Therapy

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 Registered Massage Therapy Diploma 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? ____

Physical Demand for OVCMT's Registered Massage Therapy Diploma Program:

- Sitting for long periods of time – 3 – 8 hours per day
- Standing for long periods of time – 3 – 6 hours per day
- Lifting and carrying – Up to 35 pounds - portable massage table
- Flexibility – full body visual assessment/palpation of patient, bending, squatting, kneeling, demonstrating stretches and exercises
- Ability to lie down in prone, lateral or supine positions for periods of up to 60 minutes

Does this individual have current or a history of 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.

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

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Mental Demand for OVCMT's Registered Massage Therapy Diploma Program:

- Ability to study and focus on intense material for several hours at a time
- Regular quizzes, written and oral-practical exams
- Ability to receive feedback and constructive criticism
- Rigorous class schedule – full time, Mon through Fri and daily self-study of 2-3 hours

Does this individual have a current or history of mental issues? **Yes ________** **No_________**
If yes, please indicate diagnosed conditions and status of treatment.

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Is this individual medically and physically fit to fully participate in the practical portion of the program?
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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**