Northwest Academy for the Healing Arts
Physical Examination Form

Student's Name _____ **DOB** _____ **Sex** _____

Student's Address _____

City _____ **State:** _____ **Zip Code:** _____

Physician's Name, Address, Telephone _____

History

This section is to be carefully completed by the student before participation in Northwest Academy for the Healing Arts' Massage Therapy Program in order to help detect any possible risks.

Explain "YES" answers below.
Circle questions you don't know the answer to.

1. Have you had a medical illness or injury since your last checkup or sports physical	Y / N
Do you have an ongoing or chronic illness?	Y / N
2. Have you ever been hospitalized overnight?	Y / N
Have you ever had surgery?	Y / N
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	Y / N
Have you ever taken any supplements or vitamins to help you gain or lose weight or to improve your performance?	Y / N
4. Do you think you are in good health?	Y / N
5. Do you have any allergies (for example, to pollen, medicine, food, or stinging insect)?	Y / N
6. Have you ever had a rash or hives develop during or after exercise?	Y / N
Have you ever passed out during or after exercise?	Y / N
Have you ever been dizzy during or after exercise?	Y / N
Have you ever had chest pain during or after exercise?	Y / N
Do you get tired more quickly during exercise?	Y / N
Have you ever had racing of your heart or skipped heartbeats?	Y / N
Have you had high blood pressure or high cholesterol?	Y / N
Have you ever been told you have a heart murmur?	Y / N
Has any family member or relative died of heart problems or a sudden death before the age of 50?	Y / N
Is there a family history of heart problems in a close relative younger than age 50 (examples are enlarged heart, cardiomyopathy, long QT interval, abnormal EKG, abnormal heart rhythm)?	Y / N
Have you had a severe heart infection (for example, myocarditis or pericarditis)?	Y / N
Is there a family history of Marfan's syndrome?	Y / N
Has a physician ever denied or restricted your participation in sports for any heart problem?	Y / N
7. Have you had a severe viral infection within the last month (for example, mononucleosis)?	Y / N
8. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	Y / N
9. Have you ever had a head injury or concussion?	Y / N
Have you ever been knocked out, become unconscious or lost your memory?	Y / N
Have you ever had a seizure?	Y / N
Do you have frequent or severe headaches?	Y / N
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	Y / N
Have you ever had a pinched nerve?	Y / N
10. Have you ever become ill from exercising in the heat?	Y / N
11. Do you cough, wheeze or have trouble breathing during or after activity?	Y / N
Do you have asthma?	Y / N
Do you have seasonal allergies that require medical treatment?	Y / N
12. Have you had any problems with your eyes or vision?	Y / N
Do you wear glasses, contacts, or protective eyewear?	Y / N
13. Have you ever had a sprain, strain, or swelling after injury?	Y / N
Have you broken or fractured any bones or dislocated any joints?	Y / N
Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	Y / N
If yes, explain below:	
_____	
_____	
_____	

14. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport?	Y / N Y / N
15. Do you feel stressed out?	Y / N
16. Record the dates of your most recent immunizations (shots) for Tetanus_____ Measles_____ Hepatitis B_____ Chickenpox_____	
17. **FEMALES ONLY** When was your most recent menstrual period? _____ How much time do you usually have from the start of one period to the start of another?_____ What was the longest time between periods in the last year?	
18. **ALL PARTICIPANTS: Explain "yes" answers here:**	

THE FOLLOWING QUESTIONS TO BE FILLED-IN BY PHYSICIAN:

Follow-Up Questions About More Sensitive Issues:

1. How often do you Exercise? Frequency:_____ Duration:_____ Type of Exercise:_____
2. How many hours do you sleep at night? _____ Do you wake frequently? Y N Reason for waking:_____
3. Do you feel stressed out or under a lot of pressure? Y N
4. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days? Y N
5. Do you feel safe? Y N
6. Do you drink alcohol? Y N Amount:_____ Frequency:_____
7. Do you currently smoke? Y N Amount:_____ Frequency:_____
8. Do you use chewing tobacco, snuff, or dip? Y N Amount:_____ Frequency:_____
9. Do you use recreational drugs? Y N Amount:_____ Frequency:_____ Type:_____
10. Are you currently taking any prescription drugs? Y N

    Prescription Drug Types / Names:_____

    _____
11. Do you have a history of sexual, mental / emotional, physical abuse? Y N Notes:_____

Notes About Follow-Up Questions:

MEDICAL EXAM

Height _____ Weight _____ BMI (optional) _____ % Body fat (optional) _____ Arm Span_____

Pulse _____ BP _____ /_____ (_____/ _____)

Vision: R 20/____ L 20/____ Corrected: Y / N Contacts: Y / N Hearing: R____ L____

Exam	Normal	Abnormal Notes
Appearance	Y / N	
Eyes	Y / N	
Pupils	Equal / Unequal	
Ears/Nose	Y / N	
Hearing	Y / N	
Throat	Y / N	
Dental	Y / N	
Lymph Nodes	Y / N	
Thyroid	Y / N	
Heart	Y / N	
Murmurs	Y / N	
Pulses	Y / N	
Lungs	Y / N	
Abdomen	Y / N	
Genitourinary (Male)	Y / N	
Hernia	Y / N	
Skin	Y / N	
Musculoskeletal		
Neck	Y / N	
Back	Y / N	
Shoulder/Arm	Y / N	
Elbow/Forearm	Y / N	
Wrist/Hand/Fingers	Y / N	
Hip/Thigh	Y / N	
Knee	Y / N	
Leg/Ankle	Y / N	
Foot/Toes	Y / N	

Does this patient have any local or systemic conditions that may limit their ability to safely give or receive full body Swedish or deep tissue massage? Y / N
If yes, please explain:

Additional Notes:

Physician Signature:_____ Date: _____

Physician Address:_____

Please mail this form to the Northwest Academy Admissions Department at:

2701 California Ave SW, #268 Seattle, WA 98116

I hereby authorize the release and disclosure of the personal health information of _____ ("Student"), as described below, to _____ ("School").

The information described below may be released to the School Director, or other member of the School's administrative staff as necessary to evaluate the Student's eligibility to participate in Northwest Academy for the Healing Arts Massage Licensing Program, school sponsored events, and classroom activities.

Personal health information of the Student which may be released and disclosed includes records of physical examinations performed to determine the Student's eligibility to participate in school sponsored events, including but not limited to the Pre-participation Evaluation form or other similar document required by the School prior to determining eligibility of the Student to participate in classroom or other School sponsored events.

The personal health information described above may be released or disclosed to the School by the Student's personal physician or physicians; a physician or other health care professional retained by the School to perform physical examinations to determine the Student's eligibility to participate in certain classroom activities and school sponsored events .

I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored and classroom activities, and that the School is a not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the School is covered under the state regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.

I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student's participation in certain classroom activities and school sponsored events may be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to the school address as appears below.

Name of School: Northwest Academy for the Healing Arts
School Address: 2701 California Ave SW, #268 Seattle, WA 98116

This authorization will expire when the student is no longer enrolled as a student at the school.

_____

Student Signature: Date:

_____

Student Mailing Address: Student DOB:

THE STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN THE MASSAGE LICENSING PROGRAM UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE SCHOOL