VSOHA
Vancouver School of Healing Arts

Student Health Assessment Form

STUDENT INFORMATION

Name (print last, first, middle) _____ Birth Date _____ Phone _____

Address _____ City _____ Province _____ Postal Code _____

PERSONAL HEALTH HISTORY – Please mark yes if you are receiving medical treatment presently or within the past 6 months

	Yes	No		Yes	No		Yes	No
Back Injuries	☐	☐	Heart Disease	☐	☐	Permanent limitation from		
Seizures, fainting, dizziness	☐	☐	Stomach Ulcer	☐	☐	illness, disease, or injury	☐	☐
Any type allergies	☐	☐	Skin Disease	☐	☐	Stomach, gall bladder trouble	☐	☐
Circulatory Disorder	☐	☐	Hearing difficulty	☐	☐	Nerve damage	☐	☐
Any type Hepatitis, jaundice	☐	☐	Kidney disease	☐	☐	Carpal tunnel	☐	☐
Nervous system disorder	☐	☐	Muscular disease	☐	☐	Previous broken bones/sprains	☐	☐
Respiratory disease	☐	☐	Cognitive disorder	☐	☐	Women-pregnant at this time	☐	☐
High Blood Pressure	☐	☐	Hernia	☐	☐	Joint Pain	☐	☐
Arthritis, gout, joint disease	☐	☐	Diabetes	☐	☐	Muscle Pain	☐	☐
Cancer	☐	☐	Headaches	☐	☐			

Foot Health

If any of the following are present on the foot or skin, please get it checked out and begin treatment before beginning the program. If any of the following are present during the program we can guide you to take precautions to prevent spread.

☐ Wart ☐ Corn ☐ Athletes Foot ☐ Nail Fungus ☐ Excessive Foot Odour ☐ Foot Sweating

Will any of the above prevent you from starting or finishing the program? ☐ Yes ☐ No

If answer to any of the above is yes, please explain:

Medication Allergies _____

Would you say your present health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

If you have marked yes in any part of the personal health history, VSOHA highly recommends that you consult with a physician before starting the program and by signing below you understand this recommendation.

**Signature of Applicant _____ Date: _____

**By typing your name in the Signature space, you agree to an eSignature.