Program Application for 2017/18 School Year

PO Box 222, Hancock, MI 49930 Applications are accepted at any time of the year.

Name ____
Last First Middle Preferred name

Address ____
Street City State Zip

E-mail ____________________________________ Primary phone____________________________

Home phone _________________ Emergency contact & relation to you _______________________

Work phone ______________________________ Social Security No. _________________________

Birth Date _____/_______/____________
Month Day Year

Employer ______________________________________

Are you currently a student elsewhere? _______ If yes, where _________________ Are you disabled? ________

Have you ever filed for disability compensation? ______ Do you have a learning disability? _________________

Do you have any injuries that may prevent you from giving or receiving massage therapy? _______ If yes, describe: ____

____

Do you have any special circumstance that we need to know about to best assist your learning? ______________

____

High School Graduated from or GED from ____

College ____________________________________ Degree(s) earned ________________________

Licenses and certifications ____

Other workshops, or related seminars____

Have you ever been convicted of a violation of the penal laws of any State or of the United States? ____If yes, explain (use additional paper if necessary) ____

Were you referred to INT by an INT graduate? ________If so, who and when ___________________________

Circle: Yes or No I now own a massage therapy table. If yes, you will receive a Level III tuition discount.

I hereby certify all the above statements are true. I understand that falsification or failure to disclose information on this application or any attached materials will be considered fraud and is cause for immediate dismissal from this school without refund or diploma.

______________________________________ ______________________________
Applicant Signature Date

____
Applicant's Printed name

PO Box 222, Hancock, MI 49930

Institute of Natural Therapies Professional Massage Therapist

Student Health Questionnaire

This will be used as a guideline and will remain confidential
except if the class needs to know specific contraindications for massage therapy.

Name ____ Today's Date _________________

Circle Yes or No: Do you have, or have you been informed of any of the following conditions, or health problem?

Yes No Circulatory disorders
Yes No Blood clots
Yes No Thrombosis
Yes No Phlebitis
Yes No Varicose veins
Yes No Heart disease
Yes No High blood pressure
Yes No Low blood pressure
Yes No Dizzy spells
Yes No Arthritis
Yes No Osteoporosis

Yes No Mental disorders
Yes No Neurological disorders
Yes No Numbing/tingling
Yes No Loss of sensation
Yes No Memory loss
Yes No Learning disorder
Yes No Hallucination
Yes No Visual disorder
Yes No Trembling
Yes No Audio disturbance
Yes No Closed head injury

Yes No Thyroid problems
Yes No Carpal Tunnel Syndrome
Yes No Hand/wrist pain
Yes No Digestive problems
Yes No Respiratory problems
Yes No Low back pain
Yes No Spinal pain
Yes No Low blood pressure
Yes No Diabetes
Yes No Stroke
Yes No Skin irritations

Please list any medications you are currently using ____
____

Are you presently under the care of a medical physician/chiropractor/therapist? If yes, please explain: ______________
____
____

Are you receiving care from a psychologist, social worker/counselor? If yes, please explain: _______________________
____
____

Do you have chronic body discomfort? If yes, please explain: ____
____

Past accidents, injuries, or broken bones? Surgeries? ____
____

What is your current exercise program, and/or special diet? ____
____

Do you use alcohol, tobacco, or caffeine? If yes, please specify: ____

I certify the above information is true.

Signature: ____________________________________ Printed name: __________________________ Date: ________