



Application for Admission

Please indicate desired program:

- Essentials Continuing Education (CE)
Massage Therapist (MT) Certificate Program Holistic Health Practitioner (HHP) Certificate Program
Associate Of Science (AS) Degree Program Bachelor of Arts (BA) Degree Program
Master Of Arts (MA) Degree Program

Personal Information: (PLEASE PRINT OR TYPE)

Name: Last First Middle

Mailing Address:

Primary Phone Number: Other Phone:

Social Security Number: Driver's License Number:

Date of Birth: Place of Birth:

If not a citizen or permanent U.S. resident, what is your country of residence and immigration status? (for example: alien resident, tourist visa, etc.)

Have you made previous application to IPSB? Yes No If yes, when?

In case of emergency, notify: Name

Phone: Address:

Education

Table with 5 columns: Name of Institution, From, Grad Date, Major, Degree/Diploma or # of Units. Rows include High School, College/Voc., and another College/Voc. entry.

Work Experience
(beginning with most recent)

From Month/Year	To Month/Year	Hours per week	Position	Organization	City & State
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Do you have any reservations regarding the additional weekly hours of study and time commitment required outside of class? (For example, Essentials requires practice hours and logs outside of class, as well as study and prep time.) Yes No

If yes, please explain: _____

Have you ever been suspended or expelled from any educational institution? Yes No

If yes, please explain: _____

Do you experience any disabilities or other limitations which would prevent you from giving or receiving massage? Yes No

If yes, please explain: _____

Have you ever been compelled to interrupt your work or study for a substantial period of time, or to substantially reduce your work load, due to a physical disability, illness or emotional difficulty?

Yes No

If yes, please explain: _____

I HEREBY MAKE APPLICATION FOR ADMISSION TO THE INTERNATIONAL PROFESSIONAL SCHOOL OF BODYWORK (IPSB). I DECLARE THAT THE INFORMATION AND ALL SUPPORTING DOCUMENTS SUBMITTED BY ME ARE TRUE AND CORRECT, AND THAT ANY PERSONAL STATEMENTS WERE FULLY COMPOSED BY ME. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY IPSB OF ANY CHANGES REGARDING MY APPLICATION.

Signature of Applicant: _____ Date: ____/____/____



Confidential Health Questionnaire

Student Name: _____ Date: ____/____/____

Our classes involve a considerable level of movement and activity, giving and receiving of various hands-on bodywork modalities, stretching, and movement exercises such as tai chi, qi gong, the IPSB movement series, etc. Precautions may need to be taken with these activities when certain injuries, illness, pregnancy, health concerns, or disabilities are present. In some cases, a student's participation in our program may need to be modified.

Please complete this questionnaire accurately and thoroughly. This information is for the confidential use of our faculty and will be utilized to advise you appropriately regarding participation in classes and movement.

Check any conditions listed below that you are now experiencing or have previously experienced. Please indicate the approximate dates and relevant details, as well as any residual effects.

	<u>Date</u>	<u>Details</u>
<u>Circulatory/Cardiovascular:</u>		
<input type="checkbox"/>	High/Low Blood Pressure:	_____
<input type="checkbox"/>	Phlebitis:	_____
<input type="checkbox"/>	Thrombosis:	_____
<input type="checkbox"/>	Heart Failure:	_____
<input type="checkbox"/>	Heart Attack:	_____
<input type="checkbox"/>	Edema:	_____
<input type="checkbox"/>	Varicose Veins:	_____
<input type="checkbox"/>	Heart Disease:	_____
<u>Respiratory:</u>		
<input type="checkbox"/>	Asthma:	_____
<input type="checkbox"/>	Allergies:	_____
<input type="checkbox"/>	Pneumothorax:	_____
<input type="checkbox"/>	Diseases of the lungs:	_____
<u>Musculoskeletal:</u>		
<input type="checkbox"/>	Back injury:	_____
<input type="checkbox"/>	Neck injury:	_____
<input type="checkbox"/>	Joint injury:	_____
<input type="checkbox"/>	Broken bones:	_____
<input type="checkbox"/>	Arthritis:	_____
<input type="checkbox"/>	Bursitis:	_____
<u>Cancer:</u>		
<input type="checkbox"/>	Lymphatic:	_____
<input type="checkbox"/>	Other:	_____
<u>Other:</u>		
<input type="checkbox"/>	Ulcer:	_____
<input type="checkbox"/>	Abdominal pains:	_____
<input type="checkbox"/>	Diabetes:	_____
<input type="checkbox"/>	HIV/AIDS:	_____
<input type="checkbox"/>	Headaches:	_____
<input type="checkbox"/>	Temporomandibular Joint (TMJ):	_____
<input type="checkbox"/>	Any other ailments not listed:	_____

Major surgeries: Date Details

Major illness/injury:

Mental health issues:

Hospitalization for psychiatric care: _____

Substance abuse: _____

Please indicate if you are currently experiencing any of the following conditions, and explain the nature and status of the condition.

Systemic infections: _____

Skin irritations, sores, infections: _____

Inflammatory condition: _____

Burns: _____

Are you pregnant? Yes ___ No ___ If yes, when is your expected due date? ___/___/___

Please list any prescription drugs you are taking: _____

Have you ever experienced learning difficulties or been diagnosed with a learning disability? Yes No

If yes, please explain: _____

Please indicate if you believe or know yourself to be experiencing any of the following conditions:

Attention disorders

Neurological impairment

Auditory processing problems

Perceptual deficit disorder

Dyslexia

Visual-motor coordination difficulty

Hyperactivity

Restricted memory span

Language difficulties (poor comprehension, limited verbal fluency)

Other _____

Minimal brain dysfunction

** I give consent to share any relevant material on this application with my instructors for the sole purpose of accommodating my educational needs in the classroom (please check one): YES ___ NO ___*

My signature below indicates that I have completely and accurately answered all questions.

Student Signature: _____ Date: ___/___/___



Entrance Questionnaire

Name (please print): _____ Date: ____/____/____

1. Please tell us about your interest in massage, including any experience of receiving a professional massage: _____

2. Have you ever given a formal or informal massage or attended an introductory massage class? _____

3. Please describe your personal and professional goals after completing your education at IPSB: _____

4. Please describe your previous educational experience: _____

5. How do you learn best? _____

6. How do you feel about giving massages to and receiving massages from men and women? Are there any groups or types of people that you feel you may have difficulty working with? _____

7. How do you intend to finance your education? _____

8. Do you intend to be employed while in school? How will you balance your work, family, school and study time? _____

9. How do you manage stress in your life? _____

If you have any questions or concerns about attending classes at IPSB, please note them here. An advisor will discuss them with you as soon as possible. _____

** I give consent to share any relevant material on this application with my instructors for the sole purpose of accommodating my educational needs in the classroom (please check one): YES ___ NO ___*

_____/____/____ _____/____/____
Applicant Signature Date Advisor Signature Date