



## Application for Admission

Please indicate desired program:

- Essentials (CE)  
  Continuing Education (CE)  
  Massage Therapist (MT) Certificate Program  
 Holistic Health Practitioner (HHP) Certificate Program  
  Associate of Science (AS) Degree Program

**I understand that the enclosed application fee of \$75 (\$10 for CE applicants) is non-refundable.**

Credit/Debit (Card info. attached):  Visa  MasterCard  AmEx  Discover  Cash  Check

Personal Information: (PLEASE PRINT OR TYPE)

Name: \_\_\_\_\_  
Last First Middle

Mailing Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Primary Phone Number: (    ) \_\_\_\_\_ - \_\_\_\_\_ Mobile: (    ) \_\_\_\_\_ - \_\_\_\_\_ Other (    ) \_\_\_\_\_ - \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Birth: \_\_\_\_\_

Are you a U.S. citizen?  Yes  No

If you are neither a citizen nor permanent U.S. resident, what is your country of residence and immigration status? (for example: student visa, tourist visa, etc.)

\_\_\_\_\_

Have you made previous application to IPSB?  Yes  No

If yes, please note the year of your application here: \_\_\_\_\_

How did you hear about the college? \_\_\_\_\_

In case of emergency, notify: Name: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Address: \_\_\_\_\_

### Education

	Name of Institution	From	Grad Date	Major	Degree/Diploma or # of Units Completed
High School					
City/State					
College/Voc:					
City/State					
College/Voc:					
City/State					



- All new students wishing to transfer credit from one or more previous programs of study must submit corresponding transcripts within the first quarter of their academic program at IPSB. Would you like any previous college credit considered for transfer? Yes No
- All students receiving military-related benefits must supply previous educational transcripts within the first quarter of their program. Do you intend to use the Montgomery G.I. Bill to finance part or all of your academic program? Yes No

**Work Experience**

(beginning with most recent)

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

If you have ever been suspended or expelled from any educational institution, please explain those circumstances here:

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If you experience any disabilities or other limitations which would prevent you from giving or receiving massage, please list them here:

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If you have 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, please explain those circumstances here:

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**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: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name: \_\_\_\_\_



**Confidential Health Questionnaire**

Student Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Many courses 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 a program may need to be modified.

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

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

**Circulatory/Cardiovascular:** (Please include date and details)

- High/Low Blood Pressure: \_\_\_\_\_
- Phlebitis: \_\_\_\_\_
- Thrombosis: \_\_\_\_\_
- Heart Failure: \_\_\_\_\_
- Heart Attack: \_\_\_\_\_
- Edema: \_\_\_\_\_
- Varicose Veins: \_\_\_\_\_
- Heart Disease: \_\_\_\_\_

**Respiratory:** (Please include date and details)

- Asthma: \_\_\_\_\_
- Allergies: \_\_\_\_\_
- Pneumothorax: \_\_\_\_\_
- Diseases of the lungs: \_\_\_\_\_

**Musculoskeletal** (Please include date and details)

- Back injury: \_\_\_\_\_
- Neck injury: \_\_\_\_\_
- Joint injury: \_\_\_\_\_
- Broken bones: \_\_\_\_\_
- Arthritis: \_\_\_\_\_
- Bursitis: \_\_\_\_\_



**Cancer:** (Please include date and details)

- Lymphatic: \_\_\_\_\_
- Other: \_\_\_\_\_

**Other:** (Please include date and details)

- Ulcer: \_\_\_\_\_
- Abdominal pains: \_\_\_\_\_
- Diabetes: \_\_\_\_\_
- HIV/AIDS: \_\_\_\_\_
- Headaches: \_\_\_\_\_
- Temporomandibular Joint (TMJ) \_\_\_\_\_
- Any other ailments not listed: \_\_\_\_\_

**Major surgeries:** (Please include date and details)

**Major illness/injury** (Please include date and details)

**Mental health issues:** (Please include date and details)

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 and reason(s) for use: \_\_\_\_\_

If you have ever experienced learning difficulties or been diagnosed with a learning disability, please explain here: \_\_\_\_\_



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

- |   |  |
|---|--|
| <input type="checkbox"/> Attention disorders          | <input type="checkbox"/> Dyslexia  |
| <input type="checkbox"/> Minimal brain dysfunction    | <input type="checkbox"/> Neurological impairment   |
| <input type="checkbox"/> Auditory processing problems | <input type="checkbox"/> Perceptual deficit disorder   |
| <input type="checkbox"/> Hyperactivity                | <input type="checkbox"/> Visual-motor coordination difficulty                                  |
| <input type="checkbox"/> Restricted memory span       | <input type="checkbox"/> Language difficulties (poor comprehension,<br>limited verbal fluency) |
| <input type="checkbox"/> Other _____                  |  |

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

\_\_\_\_\_ Date: \_\_\_\_\_

Signature

\_\_\_\_\_  
Print Name

**Continued on Reverse**



**Entrance Questionnaire**

**FOR ALL STUDENTS MAKING APPLICATION TO IPSB:**

1. Please tell us about your interest in massage therapy and holistic health, including any experience you may have in giving or receiving massage: \_\_\_\_\_  
\_\_\_\_\_

2. Why do you wish to study massage therapy and holistic health at IPSB? \_\_\_\_\_  
\_\_\_\_\_

3. Based on your previous educational experience, how would you describe your ideal learning environment? What educational methods (e.g., visual, discussion-based, experiential, etc.) have you found to be most effective in your learning? \_\_\_\_\_  
\_\_\_\_\_

4. Do you have any questions or concerns about giving touch to, or receiving touch from, men and women? Are there any groups or types of people with whom you might have difficulty working?  
\_\_\_\_\_  
\_\_\_\_\_

**FOR ALL NEW ESSENTIALS AND PROGRAM STUDENTS ONLY:**

1. Have you ever received formal or informal instruction in massage therapy or holistic health?  
\_\_\_\_\_

2. Please describe your personal and professional goals after completing your education at IPSB:  
\_\_\_\_\_  
\_\_\_\_\_

3. How do you intend to finance your education? \_\_\_\_\_  
\_\_\_\_\_

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

5. How do you manage stress in your life? \_\_\_\_\_  
\_\_\_\_\_

6. If you have any questions or concerns about attending classes at IPSB, please note them here:  
\_\_\_\_\_  
\_\_\_\_\_

**\* I give consent to share any relevant information on this Application, including Health and Entrance Questionnaires, 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.**

\_\_\_\_\_  
Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Print Name