



Program Application for 2019/2020 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: _____