



# SCHOOL OF INNER HEALTH

## TRAINING APPLICATION FORM

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

Home Ph: \_\_\_\_\_

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

Bus. Ph: \_\_\_\_\_

Street

Fax:: \_\_\_\_\_

\_\_\_\_\_

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

City

State

Zip Code

Date of Birth: \_\_\_\_\_

How did you hear about School of Inner Health \_\_\_\_\_

Present Occupation: \_\_\_\_\_

Employer & Location: \_\_\_\_\_

Name & Date of Program you are applying for: \_\_\_\_\_

*Please give specific and detailed answers to the following questions.*

*Typewritten responses only:*

- 1) Discuss your purpose for enrolling in this training program, and what you hope to gain from it. What are your personal goals.
- 2) Describe your academic background — including massage school and/or other somatic training. List all schools attended, graduation dates, and whether you received a certificate, diploma or degree.
- 3) Describe your current professional practice — the nature of this practice, average number of clients per week, years in practice.
- 4) Describe any training or prior experience you've had in craniosacral therapy — either through workshops, formal training, or apprenticeships.
- 5) Have you received craniosacral therapy in some form? List number of sessions in the past two years, and whether this work was from an osteopath or somatic practitioner.
- 6) Have you ever been arrested or convicted of a felony or misdemeanor crime? List dates and details.

### SEND THE FOLLOWING:

- 1) Completed Application

*For Cranial and Lymphatic Introduction courses, send only the first page.*

*If planning to attend full Cranial Certification Course the Health History on page two must also be completed.*

- 2) A non-refundable \$100 tuition deposit to:

**School of Inner Health**  
**1 Lover's Lane**  
**Manitou Springs, CO 80829**  
**Make checks payable to School of Inner Health**

**(719) 685-4805**

**email: [innerhealth@earthlink.com](mailto:innerhealth@earthlink.com)**

**Admission to this program is entirely at the discretion of: The School of Inner Health**



# HEALTH HISTORY FORM

**IMPORTANT NOTE:** All information disclosed will remain confidential; this form will be kept in the student's permanent file. Please give specific and detailed answers to all questions.

Use an additional sheet of paper (*as needed*) to answer the questions below:

## YOUR PHYSICAL HEALTH - MARK ANY OF THE FOLLOWING WHICH MAY APPLY:

- Muscular/Joint Problems       Allergies       Skin Conditions       Neurological
- Headaches/Migraines       Environmental Sensitivities       Spinal/Skeletal Problems       Smoking
- Digestive Problems       High/Low Blood Pressure       Heart Conditions       Diabetes

1. Describe any past injuries, accidents, traumas or surgeries you have experienced. Please list the approximate dates for each, and the treatment you received.
2. Are you currently under a physician's care? (medical doctor, chiropractor, osteopath, naturopath)  
If yes, list each provider's name, address and phone number.
3. Describe any and all diagnosed medical conditions you currently have.  
List when the condition was diagnosed, and any treatment regimen you are currently receiving.
4. List all prescription and non-prescription medications you are currently taking for these conditions.
5. Do you have any known history of physical or sexual abuse? \_\_\_\_  
Have you been treated for alcohol, drug or substance abuse? \_\_\_\_  
If yes, list any counseling or treatment you have received, along with the dates of treatment and the name of the provider.
6. Describe what you know about your own birth (type of birth, medical interventions, etc.)

## YOUR MENTAL & EMOTIONAL HEALTH

7. Describe any and all diagnosed psychological or emotional conditions you currently have. Please be specific and detailed. List when the condition was diagnosed and any course of treatment you have received previously for this condition, OR treatment you are currently receiving.
8. List any prescription medications you are taking for these conditions.
9. Are you working with a counselor, psychologist, psychotherapist, social worker or psychiatrist at present?  
If yes, list each provider's name, address and phone number.
10. Do you have any diagnosed learning disabilities? List the condition, along with treatment received.
11. Describe any difficulties/challenges you have with either classroom learning or at-home study work.

**By my signature here, I acknowledge that I have answered these questions to the best of my knowledge. I am aware that failure to disclose any information requested on this form may result in dismissal from the ISBC at a later date. I agree to update the school as to any changes in my health status while enrolled in the ISBC. Furthermore, I authorize you to contact the health care providers I have listed on this form, to obtain more information about any conditions which may affect my ability to participate in this Training Program.**

PRINT NAME \_\_\_\_\_

DATE \_\_\_\_\_

APPLICANT'S SIGNATURE \_\_\_\_\_

Addendum: I agree to have a professional therapist to work with between modules in the event that my personal/emotional issues arise in the course of this training. \_\_\_\_\_ Initials