



Registration Form

Child's Name: _____ D.O.B. _____

Mother's Name: _____ Father's Name: _____

Mother's Email: _____ Father's Email: _____

Address: _____

Phone: (Home) _____ (Mom Cell) _____ (Dad Cell) _____

(Work) _____ (Email) _____

Child's School _____ (Grade) _____

Teacher: _____ Teacher Contact info: _____

Siblings/Ages _____

Pediatrician : _____ (Phone) _____

Caregiver : _____ (Cell) _____

Emergency Contact : _____ (Phone) _____

Referred by: _____

Reason for visit:

Manhattan: 320 East 65th Street, Suite 124 | New York, NY 10021 | 212-772-7015

Long Island: 55 Northern Boulevard, Suite 209 | Greenvale, NY | 11548 | 516-333-6020



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Does your child receive special services at school? If yes, please describe (occupational therapy, speech therapy, physical therapy, groups, classes, etc.)

Does your child have any allergies? If yes please specify:

To assist us in scheduling and makeup sessions please advise us of your child's weekly schedule and please specify preferred days and times.

MONDAY:

TUESDAY:

WEDNESDAY:

THURSDAY:

FRIDAY:

SATURDAY:

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