A Balanced Child
Behavior and Play Therapy

Date Received ______________________

Start Date ______________________

Referred By ______________________

Enrollment Form

Child's Name ______________________ Date of Birth ______________________

Age ____________ Sex ____________ Home Phone ______________________

Address ______________________ City ____________ State ________ Zip ________

Insurance Provider ______________________ Phone ______________________

Policy # ____________ Group # ____________ Insured ____________

Physician ______________________ Phone ______________________

Preferred Hospital ______________________ Address ______________________

Parent/Guardian ______________________ Email ______________________

Address ______________________ City ____________ State ________ Zip ________

Home Phone ______________________ Mobile Phone ______________________

Employer ______________________ Work Phone ______________________

Parent/Guardian ______________________ Email ______________________

Address ______________________ City ____________ State ________ Zip ________

Home Phone ______________________ Mobile Phone ______________________

Employer ______________________ Work Phone ______________________

Authorized Pick-Up/Emergency Contact #1

Name ______________________ Phone ______________________ Relationship ____________

Authorized Pick-Up/Emergency Contact #2

Name ______________________ Phone ______________________ Relationship ____________

Health Information

Medical Diagnosis/Developmental Concerns:

____

____

Allergies (note reaction and treatment):

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Medications:

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Services

◯ Applied Behavior Analysis (ABA Therapy)

_____ Treatment Plan

_____ Medicaid

◯ Group Play

AM / PM *circle one*

_____ 3 Week Play Therapy

_____ 6 Week Play Therapy

_____ 9 Week Play Therapy

_____ Single Session (Drop-In)