



THERAPY-BASED DANCE CLASS INTAKE FORM

Child's Name (Last, First)	
DOB:	School Grade:
Parent Guardian 1:	Parent Guardian 2:
Address:	Address:
Phone Number:	Phone Number:
Email:	Email:

Child's medical history:
Any allergies?
Does your children currently work with/ worked in the past with an Occupational Therapist or Physiotherapist? If yes, please describe therapy goals:
Does your child require any mobility aids? If yes, please describe:
Does your child require any assistance with self-care activities (i.e. toileting, dressing)? If yes, please describe:

To learn more about your child's needs, please comment on the following items:	
Socialization with peers:	
Attention in a group setting:	
Participation in physical activity:	
Interest in dance/music:	



What interests you about this program?

Please provide any additional information you would like us to know about your child:

How did you hear about us?

Clinic (please specify):

Flyer

Word of mouth

Other

Thank you for your interest in Dual Therapy's Therapy-Based Dance Classes. We will contact you shortly.

Please email the completed form to info@dualtherapy.ca