**REQUIREMENTS PRIOR TO STARTING THERAPY**

1

* + Fill in the Registration Form (given below) and return via email to info@behaviourenrichment.com

2

* + If not already completed, schedule a 1 hour initial evaluation with our BCBA/BCaBA (both parents & child to attend)

3

* + After the evaluation, BCBA/BCaBA will recommend a treatment plan

4

* + Finalise schedule for therapy sessions based on availability of slots

5

* + Pay fees in advance for 3 months/6 months/yearly, as applicable

6

* + Review & sign Parent Handbook & Policies

7

* + Start sessions and schedule regular reviews

**REGISTRATION FORM**

**Please paste child’s recent photo**

**Child’s details**

|  |  |
| --- | --- |
| **Child’s name:** |  |
| **Date of Birth:** |  |
| **Sex:** | **M / F (tick as applicable)** |
| **Complete address:** |  |
| **Nationality:** |  |

**Parent/Guardian’s details**

|  |  |
| --- | --- |
| **Mother’s name:** |  |
| **Mother’s occupation:** |  |
| **Father’s name:** |  |
| **Father’s Occupation:** |  |

**Contact details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent/****Guardian** | **Mobile #** | **Work #** | **Email** |
| Mother |  |  |  |
| Father |  |  |  |

**Educational History**

|  |  |
| --- | --- |
| **School/Nursery Name, if any:** |  |
| **Address:** |  |
| **Grade:** |  |
| **Does he have 1:1 support in school (e.g., through a shadow teacher/LSA?)** |  |

**Therapy History**

|  |  |
| --- | --- |
| **Has your child received ABA, Speech or OT earlier?** | Yes / No |
| **If yes, when?** |  |
| **How many hours per week did he receive therapy?** |  |
| * ABA
 |  less than 5 hours per week more than 5 hours per week |
| * Speech
 |  less than 2 hours per week more than 2 hours per week |
| * Occupational Therapy (OT):
 |  less than 2 hours per week more than 2 hours per week |

|  |  |  |
| --- | --- | --- |
| **ABA Provider’s name & location** | **Speech Provider’s name & location** | **OT Provider’s name & location** |
|  |  |  |
|  |  |  |

**Medical History**

|  |  |
| --- | --- |
| **Is your child currently in good health?** | Yes/No |
| **Do you have concerns regarding your child’s hearing/vision?** | Yes / No |
| **Diagnosis, if any:** |  |
| **Date diagnosed:** |  |
| **Diagnosing Doctor:** |  |

**Medication, if any**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Dosage** | **Purpose** | **Prescribing doctor** |
|  |  |  |  |
|  |  |  |  |

Please list any **allergies** that your child has:

Does your child have any **feeding** challenges?

**Services (FOR OFFICE USE)**

**(Please see our FAQs document for complete list of services – fee structure mentioned in our covering email)**

| **Services** | **Hours/week***(tick as applicable)* | **Preferred Timing** |
| --- | --- | --- |
| **1:1 ABA Therapy**  |  5 hours/week 10 hours/week |  |
| **1:1 Speech Therapy** |  1 hour/week 2 hours/week 3 hours/week 4 hours/week 5 hours/week |  |
| **1:1 Occupational Therapy** |  1 hour/week 2 hours/week 3 hours/week 4 hours/week 5 hours/week |  |
| **School Readiness Program**  |  3.5 hours/day |  |
| **Social Skills Group** |  1 hour/week |  |
| **Clinical Diagnosis** |  No. of sittings to be decided by our clinical psychologist |  |

**Other comments, if any:**

**(Please feel free to give us detailed information on any other concerns that you may have)**