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# THERAPY SCHEDULE FORM

CHILD'S NAME \_\_\_\_\_

In order, which day best fits your needs for Therapy Services: (For example if Tuesday is the best day, place a one in front of it. If Friday is second best, place a two in front of it, etc...)

\_\_\_\_ Monday \_\_\_\_ Tuesday \_\_\_\_ Wednesday \_\_\_\_ Thursday \_\_\_\_ Friday \_\_\_\_ Other

Time if day preferred for your therapist's visit: \_\_\_\_\_

Will therapy be in your home? Yes \_\_\_\_ No \_\_\_\_ Comment \_\_\_\_\_

If not in your home, please give the name, address, and phone number where the therapy will be held:

Name of Day Care or Other: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Best time of day to reach you: \_\_\_\_\_

Day time phone number to reach you: \_\_\_\_\_

May we leave a message on your voice mail? Yes \_\_\_\_ No \_\_\_\_

Other considerations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent /Guardian Name: \_\_\_\_\_

Parent /Guardian Signature: \_\_\_\_\_