



Developmental Therapy Associates, Inc.

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Bike Riding Lessons Registration Form

Client's Name: _____	Date of Birth: _____
Age: _____	Gender: _____
Medications taken: _____	Allergies: _____
Medical limitations: _____	Known diagnosis: _____
Person completing the form: _____	Relationship to child: _____
Date completed: _____	
Father's Name _____	Mother's Name: _____
Address: _____	Address: _____
_____	_____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Cell Phone: _____	Cell Phone: _____
E-mail: _____	E-mail: _____
Best times to reach: _____	Best times to reach: _____

How did you hear about the DTA bike riding clinic? _____

Are you a current DTA client? If so, who is your therapist? _____

Please help us understand the individual's current level of skill when riding his/ her bike:

(Check all that apply):

- | | |
|-----------------------------------|-------------------------------|
| • Currently using training wheels | • Follow 1-2 step directions |
| • Pedal independently | • Have appropriate endurance |
| • Maintain balance | • Use hand brakes |
| • Able to start the bike | • Able to turn around corners |
| • Able to steer the bike | • Fearful of bike riding |
| • Able to brake | • Excited about bike riding |
| • Aware of safety concerns | • Maintain necessary speed |

Please describe any additional concerns you might have:

Please indicate strengths, motivators, and/ or special interests:

*Cost is \$50 due at time of service, not reimbursable by insurance. Please give 24 hours notice for cancellations. Sessions will be re-scheduled for inclement weather.

*Please return this form to DTA prior to 1st session via mail, fax, or e-mail. Thank you!