SENSORY SPACE®
THERAPY CENTRE

# Adult Registration Form (ARF)

## Personal details:

Date: _____

Name:_____

DOB:_____

Medical issues/Allergies_____

_____

First Language _____

Address:_____

_____

Telephone:_____ Email: _____

GP name and phone number

_____

_____

I agree my details to be shared with my GP ☐

## Services you require:

☐ Speech&Language Therapy
☐ Occupational Therapy
☐ Nutritional Therapy
☐ Play Therapy
☐ Music Therapy
☐ Art Therapy
☐ Drama Therapy
☐ Psychology Services
☐ Not Sure

We can contact you to arrange appointments: by email ☐ by phone ☐ by post ☐

We can contact you to send all relevant documents: by email ☐ by post ☐

Please return the completed form by post to:

**Sensory Space**
**Unit 5**
**Dublin Road**
**Drogheda**
**Co. Louth A92 XE86**

Alternatively, scan and email to: **info@sensoryspace.ie**

If you have any queries, please phone: **041 980 3307**