piedmont music therapy

Music Therapy Intake Form

Questions on this form are for the purpose of collecting information in order to develop an individualized music therapy program to meet your family member's needs. Information is confidential.

CONTACT INFORMATION

Name:_____Date of Birth:_____ Gender:_____Dominant Hand:____

Phone Number: _____ (Cell) _____ (Work)

Email address: _____

Mailing address: _____

Emergency Contact:_____ Relationship: _____

Phone Number: _____ (Cell) _____ (Work)

Preferred method(s) of communication:_____

ENROLLMENT INFORMATION

Please indicate below:

__ Individual Music Therapy Session (30/45/60 minutes)

__ Support Group

- __ Parkinson's Disease
- __ Veteran
- __ Parents of Medically Fragile Children
- __ _____

Personal Availability for INDIVIDUAL MT SESSIONS:

- **Monday:** Can begin as early as _____ and finish as late as _____.
- **Tuesday:** Can begin as early as _____ and finish as late as _____.
- **Wednesday:** Can begin as early as _____ and finish as late as _____.
- **Thursday:** Can begin as early as _____ and finish as late as _____.
- **Friday:** Can begin as early as _____ and finish as late as _____.
- **Saturday:** Can begin as early as _____ and finish as late as _____.

Received by PMT Staff:_____ Date:_____

PMT Music Therapist Provider Assigned:_____

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GENERAL:

WHERE and WITH WHOM does your family member live? _____

_____

Name and Age(s): _____

Pet(s):_____ Religion:_____

Other helpful information about your family member and family unit:_____

_____

Medical condition/diagnoses:_____

_____

_____

Food sensitivities/allergies?_____

If Yes, please complete addendum.

Medications that may impact session:_____

_____

Other restrictions/considerations:_____

_____

_____

MUSIC INFORMATION:

Has your adult family member received music therapy services? Yes No

If so,

describe:_____

Has your adult family member received music lessons? Yes No

If so,

describe:_____

Preferred radio station, CDs, stations for Spotify/Pandora:

:_____

_____

_

Instrument preferences:_____

_____

_

Sound

sensitivities:_____

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Access or use: CD / DVD/ Computer / Smart Phone / iPad

GETTING TO KNOW MORE YOUR FAMILY MEMBER

PROFESSION or TRADE:
HOBBIES:
What do you anticipate from music therapy treatment?
Any other information you would like to share prior to your family member's assessment?

OTHER TREATMENT & SERVICES

Please list other therapies received and service providers.

Other therapy _____ and Service provider: _____

Other therapy _____ and Service provider: _____

Other therapy _____ and Service provider: _____

GOAL AREAS

Please share your family member's *strengths* and *needs* in the following areas:

Motor Skills:_____
_____

Sensory Skills:_____
_____

Communication Skills: _____
_____

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Emotional Skills:_____
_____

Social Skills:_____
_____

CONSENT FOR TREATMENT:

I consent to my adult family member:
(WRITE FULL NAME)_____ receiving music therapy services from Piedmont Music Therapy, LLC.

_____ _____
Signature of POA Date

_____ _____
Written Name of POA Relationship to Client

Please return to:
Piedmont Music Therapy, LLC
director@piedmontmusictherapy.com
220 Westinghouse Boulevard - Suite 402
Charlotte, NC 28237

Received by PMT Staff:_____ Date:_____
PMT Music Therapist Provider Assigned:_____