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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 needs. Information is confidential.

CONTACT INFORMATION

Name:________________Date of Birth:___________ Gender:______________

Phone Number: _____________ (Home) __________ (Cell) ________________ (Work)

Email address: ________________________________

Mailing address: ____

Emergency Contact:__________________________________ Relationship: _____________

Phone Number: _______________ (Home) ______________ (Cell) ______________ (Work)

Preferred method of communication:________________________________

ENROLLMENT INFORMATION

Session preference:

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

__ Support Group

 __ Parkinson's Disease

 __ Veteran

 __ Parents of Medically Fragile Children

 __ ________________

Personal Availability for INDIVIDUAL 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:____________________________

GENERAL:

With whom does do you live? ____

Name and Age(s): ____

Pet(s):_________________________ Religion:____________________

Other helpful information about family:____________________________________

____

Medical condition/diagnoses:____

____

Food sensitivites/allergies?____

If Yes, please complete addendum.

Medications that may impact session:____________________________________

____

Other restrictions/considerations:____

____

____

MUSIC INFORMATION:

Have you received music therapy services? Yes No

If so, describe:____

Have you taken music lessons? Yes No

If so, describe:____

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

:____________________________

____

Instrument preferences:____

____

Sound sensitivities:____

Received by PMT Staff:___________________________ Date:_________________

PMT Music Therapist Provider Assigned:_________________________

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

GETTING TO KNOW YOU

PROFESSION or TRADE:
HOBBIES:
What do you anticipate from music therapy?
Any other information you would like to share prior to meeting?

OTHER TREATMENT & SERVICES

Please list your other therapies received and service providers.

Other therapy ____________ and Service provider: ______________________________________

Other therapy ____________ and Service provider: ______________________________________

GOAL AREAS

Please share your *strengths* and *needs* in the following areas:

Motor Skills:____
____

Sensory Skills:____
____

Communication Skills: ____
____

Emotional Skills:____

Received by PMT Staff:________________________________ Date:____________________

PMT Music Therapist Provider Assigned:______________________________

____

Social Skills:____
____

CONSENT FOR TREATMENT:

I consent to receiving music therapy services from Piedmont Music Therapy, LLC.

____ _________________

Signature Date

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:________________________