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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 the client's needs. Information is confidential.

CONTACT INFORMATION

Client Name:__________________Date of Birth:___________ Dominant Hand:_______

Parent/Guardian Name: ____________________________ 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) __Group Music Therapy Session

Indicate availability for session times next to each day, below:

- **Monday:** Client can begin as early as ______ and finish as late as ________.
- **Tuesday:** Client can begin as early as ______ and finish as late as ________.
- **Wednesday:** Client can begin as early as ______ and finish as late as ________.
- **Thursday:** Client can begin as early as ______ and finish as late as ________.
- **Friday:** Client can begin as early as ______ and finish as late as ________.
- **Saturday:** Client can begin as early as ______ and finish as late as ________.

GENERAL:

Received by PMT Staff:_____________________________ Date:___________________

PMT Music Therapist Provider Assigned:___________________________

With whom does client live? ____
Sibling(s) Name and Age(s)____

Pet(s)____
Religion:_____________

Other helpful information about family:____________________________________
____

Client's medical condition/diagnoses:_____________________________________
____

Food sensitivites/allergies?____
If Yes, please complete addendum.

Medications that may impact session:_____________________________________
____

Other restrictions/considerations:_______________________________________
____
____

MUSIC INFORMATION:

Has the client received music therapy services? Yes No
If so,
describe:____
Has the client taken music lessons? Yes No
If so,
describe:____
Preferred radio
station/CDs:____
Instrument and artist preferences:_______________________________________
____
Sound
sensitivities:____
Access or use: CD / DVD/ Computer / Smart Phone / iPad

Received by PMT Staff:_________________________ Date:________________
PMT Music Therapist Provider Assigned:________________________

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OTHER SERVICES/EDUCATION

Current educational or vocational setting:____

Grade: ___________________ Class size: ______________________ Aide: Yes / No

IEP: Yes / No Caseworker:_____________________________ Phone #:_________________

Other therapy (SLP/PT/OT) Service provider: ____

Other therapy (SLP/PT/OT) Service provider: ____

Other therapy (SLP/PT/OT) Service provider:____

Other therapy (SLP/PT/OT) Service provider: ____

GOAL AREAS

Please list client's *strengths* and *needs* in the following areas:

Motor Skills:____
____

Sensory Skills:____
____

Communication Skills: ____
____

Emotional Skills:____
____

Social Skills:____
____

Received by PMT Staff:_________________________________ Date:____________________

PMT Music Therapist Provider Assigned:_____________________________

OTHER

Client's personality could be described as:____

Overall strengths of client:____

____

Client's areas of need:____

____

What do you anticipate from music therapy?____

____

Other comments:____

____

____

____

I consent to my child receiving music therapy services from Piedmont Music Therapy.

____ ______________________

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:_____________________________