MUSIC THERAPY INTAKE

Date of Intake:_____

Client Name:_____ DOB:_____
Sex: _____M _____F Age:_____
Phone: Cell_____ Home:_____
Email:_____
Address:_____
Secondary Contact:_____ Relationship:_____
Phone:_____ Email:_____
Living Situation:_____
Church attended/Spiritual background:_____
Likes:_____
_____
Dislikes:_____
_____

Medical Information
Diagnosis(es):_____
Seizures: ____Y ____N Frequency:_____ Severity:_____
Instructions:_____
Significant Medical Info:_____
_____
Medications:_____
Side Effects:_____
Special Diet:_____
Primary Care Physician:_____ Phone:_____

Current Services
____Speech Therapy
____Occupational Therapy
____Physical Therapy
____Music Therapy (from other provider)
____Art Therapy
____Dance Therapy
____Other (_____)
____No current services

Client characteristics/Background:

_____
_____
_____
_____
_____

Information from other practitioners/service providers:

_____
_____
_____

Music Preferences
Favorite Music:_____
_____
Previous Music Involvement (playing, singing, listening, etc.)_____
_____
_____

Please describe any concerns you have with the client's current quality of life:

_____
_____
_____
_____
_____

Your reason for seeking Music Therapy Treatment:

_____
_____
_____
_____
_____

What you expect to gain from Music Therapy:

_____
_____
_____
_____
_____
_____