Music Therapy in the Children's Outpatient Clinic at Helping Hand Center
Intake Form

Name:____

Date of Birth:__________ **Sex:**__________ **Current Age:**__________

Address:____

City:________________ **State:**__________ **Zip code:**________

Does your child have an official diagnosis? Yes No

If yes, what is his/her diagnosis?________________________

____

Why are you interested in music therapy services for your child?______

____

____

Language spoken in home environment:____________________

What language(s) does your child know/speak?________________

____

____

Parent(s)/Guardian(s) Contact Information:

Name(s):______________________________________

____

Address:____

City:________________ **State:**__________ **Zip code:**________

Home phone:________________ **Work phone:**____________

Cell phone:________________ **Email:**______________

Emergency Contacts:

First Emergency Contact:

Name(s): ____

____

Address: ____

City: ____________________ **State:** __________ **Zip code:** ________

Home phone: __________________ **Work phone:** ______________

Cell phone: ____________________ **Email:** __________________

Second Emergency Contact:

Name(s): ____

____

Address: ____

City: ____________________ **State:** __________ **Zip code:** ________

Home phone: __________________ **Work phone:** ______________

Cell phone: ____________________ **Email:** __________________

Third Emergency Contact:

Name(s): ____

____

Address: ____

City: ____________________ **State:** __________ **Zip code:** ________

Home phone: __________________ **Work phone:** ______________

Cell phone: ____________________ **Email:** __________________

About Your Child:

Child's Likes:

Child's Dislikes:

Child's Strengths:

Areas to Improve:

How does your child respond/interact with friends and peers?

How is your child within the academic setting?

How is your child within the home environment?

What do you consider your child's strengths academically and socially?

How does your child respond to new people and/or environments?____________________

Does your child typically trust people?____________________

How does your child communicate? (i.e. pictures, verbally, device, etc.)____________________

<u>Home and Family Dynamics:</u> Please list all immediate family members, their relationship with your child, and if they live at home with your child.

Name	Family Relation	Age	Does this individual live at home?

How did you hear about us?____________________

Who was your child referred by?____________________

Child's Regular Physician:____________________

Physician's Address:____________________

City:__________ **State:**__________ **Zip code:** __________

Phone number:____________________

Fax number:____

Does your child have any allergies? If so, please list them:______________________

Does your child currently take any medications? If so, please list them:___________

Please list all therapies that your child is currently receiving:________________________

Does your child already receive music therapy services? If yes, please include contact information for the music therapist.____

Name:____

Phone number:____

Email:____

May I contact them?__________

Please list current therapist(s) and contact information:

Name:____

Type of therapy:____

Phone number:____

Email:____

May I contact them?__________

Name:____

Type of therapy:____

Phone number:____

Email:____

May I contact them?__________

Name:____

Type of therapy:____

Phone number:____

Email:____

May I contact them?______________

Name:____
Type of therapy:____
Phone number:____
Email:____
May I contact them?______________
Please list all therapies and/or treatments that your child previously received.
Please include the child's age during treatment.

Type of Therapy	Age of child when receiving therapy

Please include the following with this form:
________**Most recent Psychological Evaluation**
________**Individualized Education Plan**
________**Treatment Plans and Summaries of all therapies that your child receives.**

Developmental Milestones:

At what age did your child walk?_______________

At what age did your child begin vocalizing?_________________

At what age did your child begin talking?____________________

At what age did your child become toilet trained?__________________

Does your child feed him/herself?____________________

Is there anything else that you would like me to know about your child?_______________
____
____
____
____
____
____