

Music Therapy Pre-Assessment Information

NAME _____

DOB _____

CONTACT INFORMATION

Address _____ City, State _____ Zip _____

Cell Phone _____ Work Phone _____ Email _____

Diagnosis _____

Educational
background/grade _____

Vocational Status (if applicable)

Medical History (please include any allergies or other info that may impact treatment)

Medications _____

Concurrent Therapies (if applicable)

Interests/Strengths _____

Reason for Music Therapy Referral

Please provide all pertinent info (issues noted, strengths, concerns, etc.) for the following areas:

Communication:

Social:

Sensory Sensitivities (tactile defensiveness, sound sensitivity, etc.):

Behaviors:

Motor:

Responses to music:

What areas or objectives would you most like to see addressed through music therapy services?

Client/Caregiver/Parent/Guardian

DATE