Music Therapy Client Information

PARENT/GUARDIAN QUESTIONAIRRE FORM

What is Music Therapy?

Music therapy is the prescribed application of music and music related strategies, *by a board certified music therapist*, to influence brain functioning to assist or motivate a person toward specific *nonmusical goals.* Simply put, music is used as a tool to reach nonmusical goals. The application of music therapy can provide a means of verbal and nonverbal communication, stimulate memory, develop sensory awareness, focus attention, increase social interaction and physical functioning, facilitate creative expression and aid in the learning and retention of information.

Client Name: ____

Sex: ___ male ___ female DOB/age: ______________________________

Disability Primary: ____

Secondary: ____

Address: ____

____

phone #: __________________________________ email: ____

Cell #(s): ____

Parent/Guardian: ____

Sibling name(s) and age(s): ____

____

Emergency Contact Information (if not able to reach parents):

Name: ______________________________ Phone: ____________________

Relationship: ______________

Name: ______________________________ Phone: ____________________

Relationship: ______________

Background Information

Grade Level/Educational setting: ____

Current Services/Frequency/Location/Goals & Objectives:

1. SLT____ frequency & location____
G/o

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2. OT ____ frequency & location____
G/o

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3. PT ____ frequency & location____
G/o

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4. Medical ____ frequency & location____
G/o

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5. Psychological ____ frequency & location____
G/o

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6. Home Program____

7. Other:____

Speech/Language skills:
Please describe primary means of communication (sign, augmentative communication device, gesture, vocal – words, phrases, etc)____
____

Please check all that apply:

Expressive: ___Babbles ___Repeats words/perseverates/echolalic
___One-two word responses ___Talks in sentences
___Gives hand signals or uses sign language-Which?

Receptive: ___Comprehends verbal directions (touch, give me, point, etc.
___Comprehends descriptions
___Comprehends facial and body gestures

Behavioral issues/triggers/defensiveness/sensitivities:_______________________________________

General

*Strengths:*____

Areas of Need: ____

*Parental/Guardian Goals/Objectives/Concerns:*____

*OtherInformation:*____

Music Specifics

1. Does your child demonstrate a significant increased response to musical stimuli? Please circle the appropriate responses and comment below
   a. increased alertness/attention
   b. verbalizes/sings single words to complete phrases
   c. demonstrates increased motivation to complete directed tasks
   d. moves body in response to music

   comments:

2. Please list any particular songs and/or instruments your child likes and/or attends to:

3. Please state why you believe music therapy will be beneficial or necessary for your child to progress in regard to developmental goals and objectives.

___________________________________ _____________________

Parent signature Date

Thank you again for your time and cooperation.

Please return to:
Therapy Connections of South Texas
3458 S. Alameda Street
Corpus Christi, TX 78411
361-815-2433 * therapyconnections@att.net

MUSIC THERAPIST USE ONLY

Date/Time:___________________________ Location:____

Interviewed/Observed by: ____