Music Therapy Questionnaire

Date: _____
Child's Name: _____
Gender: Male Female Other:_____
Date of Birth:___________
Address _____ Phone:_____
Medical/Educational Diagnosis:_____
Diet Restrictions:_____ Previous Diet Programs: _____
Medications: _____
Allergies/Precautions:_____
EpiPen?_____
Hearing Screen: YES/NO Comments:_____
Vision Screen: __YES/NO Comments:_____

Parent/Guardian's Name:_____Relationship:_____
_____ Occupation:_____
Address: _____
Phone: _____ Cell Phone:_____
E-Mail:_____ Preferred Means of Contact: _____

Parent's/Guardian's Name:_____ Relationship:_____
_____ Occupation:_____
Address (If Different): _____
Phone: _____ Cell Phone:_____
E-Mail:_____ Preferred Means of Contact: _____

Siblings:	Name	Age
	_____	_____
	_____	_____
	_____	_____

Social History	**Comments**
Lives with:	
Attends School/Daycare:	
School-Based Services: Current Provider Name(s):	
Other Providers: Present: Past:	
Primary Language in home:	
Ethnicity:	

Birth History	**Comments**
Child was:	____Full Term ____Premature:_____wks _____Caesaren
Weight:	____lbs ____oz
Complications during the pregnancy?	____No ____Yes: Explain
Complications during delivery?	____No ____Yes: Explain
Other Important Information:	

Developmental History:

Roll tummy to back at _____months.
Roll back to tummy at ____months.
Sit independently at _____months.
Crawl at _____ months.
Walk without support at_____months.

Babbled at _____months.
First word at _____months.
Put 2 words together at_____months.
Sentences at _____months.
Gestures to communicate at ____months.

Toilet Training:
_____ Trained _____In Process _____Not Trained

Medical History:

Surgeries/Procedures Since Birth_____
_____
Hospitalizations Since Birth_____
_____
Medical Tests/Results_____
_____
History of:_____
_____
_____

History of seizures?_____
Sleeping Concerns_____
_____

How does your child communicate?
☐uses sentences
☐uses single words
☐babbles or uses sounds
☐uses signs
☐uses gestures (pointing, reaching)
☐uses pictures
☐uses eye gaze to show what s/he wants
☐takes you to a desired object
☐sings directions
☐imitates or mimics other voices

Other comments:_____
_____
_____
_____

Parent Goal Priorities:
What activities does your child enjoy? What is a good way to motivate him/her?
_____
_____
_____

What are some of your child's strengths? _____
_____
_____
_____
_____

What are some areas you would like music therapy to assist in your child's development?
_____
_____
_____
_____
_____

Does your child have any favorite songs? ☐YES ☐NO
If so, please specify:_____
_____
_____
_____

Does your child have any favorite non-music and music related activities? ☐YES ☐NO
If so, please specify:_____
_____
_____
_____

Does your child have any musical toys or instruments? ☐YES ☐NO
If so, please specify:_____
_____
_____
_____

Does your child have any sensitivity to certain music, noises, or other sounds that you think I should be aware of? ☐YES ☐NO
If so, please specify:_____
_____
_____
_____
_____

Are there any questions/concerns regarding music therapy you would like me to answer?
_____
_____
_____
_____
_____

Special THANKS!!!!

Thank you for taking the time to complete this form. All of the information shared will be kept confidential and be used to best serve your child's needs. I am enthusiastic about your decision to participate in music therapy!

Ericha Rupp, MA, MT-BC