

General Information

Client Name: _____	Age: _____	Gender: _____
Preferred nickname: _____	Year if in school: _____	Employed: Y / N
Parent Names (if relevant): _____ _____	Date of Birth: _____ _____	
Legal Guardian? _____ _____	Date of Referral: _____ _____	
Address (es): _____ _____ _____ _____	Known Allergies: _____ _____ _____ _____	

Contact Information

Home Phone: _____ Cell: _____ Email: _____	How would you prefer we contact you concerning appointments? <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email
Emergency Contact Name: _____ Emergency Contact Relation: _____	Emergency Contact Phone: _____
Additional contact information or concerns you'd like us to know:	Additional Notes:

Health Information

<p>Medical history/ any major illnesses or surgeries since conceived:</p> <hr/> <hr/> <hr/> <hr/>	<p>Primary Diagnosis (if any):</p> <hr/> <hr/> <hr/> <hr/>
<p>Other Diagnoses: _____</p> <hr/> <hr/> <hr/>	<p>Do you agree with the diagnosis/es?</p> <hr/> <hr/> <hr/> <hr/>
<p>Who gave the diagnosis/es? _____</p> <hr/> <hr/> <p>When were these diagnoses made?:</p> <hr/> <hr/>	<p>Current Medications:</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

Other Therapies/Treatments Received:

<hr/>	How often? _____
<hr/>	How often? _____
<hr/>	How often? _____
<hr/>	How often? _____
<hr/>	How often? _____

Music/Art/Movement Information

What is the typical role of music/art/dance in your home?

What are some of your favorite artists, musicians, performers, or music/art/dance experiences that you have had?

How do you usually respond when you are making music/art or moving?

What are your favorite materials/instruments/props to use when making music/art or dancing?

Insights and Concerns

We value everything you have to say about your treatment. Please feel free to use the back of this form or attach additional pages/reports/documents/notes if necessary.

Please describe your strengths:

Please describe your health concerns:

Please describe why you sought out music/art therapy treatment:

Please describe if you have any sensitivities (noises, lights, textures, tones of voice, etc):

Please describe any recent changes to your environment/routine:

Please describe what helps to calm you:

Anything else you'd like us to know?

Goals and Objectives

What areas would you like to see addressed in expressive therapy?

What outcomes do you hope to see as a result of expressive therapy?

Are there any ideas you have about how we can address your goals together?

Anything else you want to share with us?

Thank you for taking the time to help us get to know you!

We want to remind you that we will not share this information with anyone unless you give us permission to do so, if we are required by law, or if your safety or the safety of someone else is jeopardized. By signing the informed consent signature page you are confirming through documentation that you have read and received your rights, including appropriate HIPPA documents, WCET' legal requirements regarding you and your family's safety, and confidentiality. We are happy to discuss any of this with you at any time in person or over the phone.