General Information

Client Name:	Age: Gender:
Parent Name(s), ____________________ ____________________ Are above listed legal guardians? Y / N If no, please briefly explain: ____________________ ____________________	Date of Birth: ____________________ Date of Referral: ____________________ Anticipated Start Date: ____________________
Address: ____________________ ____________________	Allergies: ____________________ ____________________

Contact Information

Home Phone____________________ Cell____________________ Email____________________	How would you prefer we contact you concerning appointments? ❑ Home Phone ❑ Cell Phone ❑ Email
Emergency Contact Name:	Emergency Contact Phone:
Emergency Contact Relation:	Note:

Health Information

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

Other Therapies/Treatments Received:

______________________ How often?______________

______________________ How often?______________

______________________ How often?______________

______________________ How often?______________

______________________ How often?______________

Insights and Concerns

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

Please describe your child's strengths:

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Please describe health concerns:

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Please describe any behavioral concerns:

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Please describe if your child has sensitivities (noises, lights, textures, tones of voice, etc):

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Please describe any recent changes to your child's environment/routine:

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Please describe what helps to calm your child:

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____

Anything else you'd like us to know?

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Goals and Objectives

What areas would you like to see addressed in therapy?

◯ Social Skills

◯ Emotional Concerns

◯ Behavioral Concerns

◯ Kinesthetic/Motor Functioning/Physical Goals

◯ Communication/Language Skills

◯Attention/Focus/Memory Skills

◯ Sensory Perception

Other: ____

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

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Anything else you want to share with us?

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

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 the safety of your child or someone else depends on it. You can read more about our confidentiality policy in the document titled "Informed Consent." We are happy to discuss any of this with you at any time in person or over the phone.

Audio/Video/Information Release

At Worcester Center for Expressive Therapies, we are committed to maintaining confidentiality and honoring your privacy. We will not share any information about you or your child without your consent. In some cases, though, sharing an experience we had with your child in music therapy can help to improve the overall quality of care for future music therapy clients. Because of this, we ask you to consider the following:

I, ____ grant Worcester Center for Expressive Therapies permission to share, video footage, audio recordings and still image photographs that are taken of my child during music therapy sessions if they are used for the following purposes:

- ❏ Educational (conference/community presentations, sharing with students, etc.).
- ❏ Research (for reference and/or publication in scholarly journals, books, etc.).
- ❏ Promotional (still images for use in Worcester Center for Expressive Therapies brochures, website, etc.).
- ❏ Regarding personal information (diagnoses, presentation in music, behaviors, treatment plan(s), and other information deemed clinically relevant by the music therapist):

- ❏ I give permission for my child's case to be discussed with the therapist's supervisor(s) and other clinicians at Worcester Center for Expressive Therapies to improve the quality of his/her care.
- ❏ I give permission for my child's case to be discussed with the other healthcare professionals who make up my child's treatment team in an effort to increase integration and cohesion among his/her various therapeutic experiences. In this case, I give permission for my child's first and last name to be used.

Regarding the use of my child's name in the above scenarios:

- ❏ I give Worcester Center for Expressive Therapies permission to use my child's first name.

- ❏ I understand that my responses on this form will not affect my child's treatment in

music therapy and that I am free to grant or withhold permission of any of these things to any extent. To indicate the cases in which I do not give my consent, I have written the word “No” next to the box. I also understand that Worcester Center for Expressive Therapies will keep my child’s name confidential unless otherwise indicated above.

Signature of parent/guardian:___________________________________ Date:_____________