UPSTATE MUSIC THERAPY CENTER LLC
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Penfield, NY 14526
Phone: (585) 377-1000

MUSIC THERAPY ASSESSMENT
History Questionnaire

Name of Child_____ D.O.B._____

Parent Name(s) _____

Address _____City_____ Zip_____

Phone (h)_____ (w)_____

School District _____

1. Does your child have a formal diagnosis? (if yes, please specify) (if no, please list concerns)

2. Does your child have any visual or hearing difficulties?

3. Does your child exhibit any noticeable sensitivity to sound, touch or movement?

4. Does your child have any physical limitations, behavior needs or medical concerns that the evaluator should be aware of?

5. Does your child have any siblings? (How many, ages and special needs)

6. Does your child attend pre-school or a school-age program? (if yes, specify name and days/hours)

7. What therapies is your child currently receiving?

8. What types of responses have you seen your child have to music?

Items to enclose or bring to the evaluation: A copy of your child's IFSP or IEP, most recent reports from current therapists and documentation from a developmental pediatrician if appropriate.

By signing below, you are providing approval for the music therapist assessing your child to video or audiotape, if indicated, to be recorded <u>solely</u> for collecting data to be used in the assessment report. It will be reviewed only by the evaluator and director of the agency. It will then be removed from the tape unless additional approval has been provided, for its use in an upcoming educational training.

_____ _____

Signature Date