



HEALING SOUNDS
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ADULT INTAKE INFORMATION

Welcome to Healing Sounds Music Therapy. Please fill out all information as completely as possible. Information given is strictly confidential and will help in providing the best possible service. Feel free to ask questions, if needed. Your music therapist will discuss the information with you after reviewing the form.

Name: _____ Date today: _____

Full address: _____

Home phone: _____ Cell phone: _____
(may call: Yes No Leave message: Yes No) (may call: Yes No Leave message: Yes No)

Email address: _____
(may we e-mail: Yes No)

Occupation: _____

Employer: _____ How long: _____

Work phone: _____ (May call: Yes No Leave message: Yes No)

Preferred method of contact: Home # Cell # Work # Email (please circle all that apply)

Gender: Male Female Date of Birth: _____ Age: _____

Primary Language: _____ Ethnicity: _____

Religious affiliation: _____

(We respect individuals of any age, gender, ethnicity, race, religion, and sexual preference. Gathering the above information can help ensure that your music therapist is respectful of your family's background and beliefs.)

Current living arrangements:

Family of origin _____	Relatives _____	Single _____
Married _____	Roommate(s) _____	Single parent _____
Married w/children _____	Significant other _____	Domestic partner _____
Domestic partner w/children _____	Widow(er) _____	Other _____

In case of emergency, contact _____
Full name Relationship Phone #



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GENERAL INFORMATION

Briefly, please state what issue(s) bring you to seek music therapy services.

Are you presently receiving counseling or mental health services elsewhere? Yes No
(If yes, do not complete this form until you have talked with your counselor/therapist.)

Family members receiving services with Healing Sounds Music Therapy: Yes No
Names/Dates of service: _____

Have you ever seen a mental health professional (psychiatrist, psychologist, or counselor)? Yes No
(If so, we may need your permission in order to communicate with that individual or agency.)

Previous Mental Health Professional/Agency: _____
Address: _____
Phone: _____ Dates of Service: _____

Have you been hospitalized or confined for mental health concerns? Yes No
If yes, when? _____ where? _____

Are you seeking music therapy services because you are a victim of a crime? Yes No
If yes, please provide a brief explanation

Did it result in legal action? Yes No If yes, please explain

If yes, is involvement with the legal or judicial system currently ongoing? Yes No
If yes, please list names of any lawyers, detectives, & other persons involved

(If involvement with the legal/justice system is current, please provide your music therapist with the status of any current court orders involving counseling services.)



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Last year of education completed:

8th grade or below _____

Trade School _____

Master's Degree _____

High school _____

Some college _____

Ph.D. degree _____

GED _____

College graduate _____

History of learning, emotional, or behavioral problems: Yes No

If yes, please explain briefly

Spiritual/religious upbringing and current beliefs:

History of alcohol/drug/substance abuse: Yes No

If yes, please explain briefly

History of domestic violence: Yes No

If yes, please explain briefly

History of violence in family of origin: Yes No

If yes, please explain briefly

History of criminal activity: Yes No

If yes, please explain briefly

Are you currently on probation? Yes No If yes, Probation Officer _____



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HEALTH

Primary Care Physician: _____
Name Phone

Address _____

Date of LAST complete physical _____

Physical Disability: Yes No (if yes, please explain) _____

Chronic illness: Yes No (if yes, please explain) _____

Terminal illness: Yes No (if yes, please explain) _____

Check the following items for a diagnosis or medication that you are now receiving or have received:

Diagnosis	Current	Past	Date of Diagnosis	Medication Name	Dosage
Depression	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____
ADD	_____	_____	_____	_____	_____
Conduct Disorder	_____	_____	_____	_____	_____
Learning Disability	_____	_____	_____	_____	_____
Anxiety/Nervousness	_____	_____	_____	_____	_____
Panic Attack	_____	_____	_____	_____	_____
Bipolar	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____
Oppositional Defiant Disorder	_____	_____	_____	_____	_____
Mood/Anger	_____	_____	_____	_____	_____
Tics	_____	_____	_____	_____	_____
Insomnia/Sleeplessness	_____	_____	_____	_____	_____
Obsessive/Compulsive	_____	_____	_____	_____	_____
Addictions	_____	_____	_____	_____	_____
Seizures	_____	_____	_____	_____	_____
PTSD	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

(If you do not know the name and dosage of current medication(s), please bring the medication to your next session.)



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If you have been diagnosed, who gave the diagnosis?

Counselor/Psychologist _____ Family Physician _____ Psychiatrist _____

School Psychologist _____ Other _____

Name: _____ Phone #: _____

What other medication are you currently taking?

Medication	Dosage	For what reason?
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT CONCERNS

Indicate severity of up to 10 items that currently apply to you. (1=mild; 2=moderate; 3=severe)

Circle the item that you see as the most significant issue.

- _____ Abuse (physical, emotional, sexual)
- _____ Adjustment to life changes (job loss, divorce, getting married, aging, relocation, etc.)
- _____ Career decisions
- _____ Disturbing memories (past abuse, neglect, other traumatic experience)
- _____ Drug or alcohol use (both legal and illegal drugs)
- _____ Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet, etc.)
- _____ Family or Stepfamily relationship problems
- _____ Feeling angry or irritable
- _____ Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
- _____ Feeling guilty or shameful
- _____ Feeling sadness or depression NOT related to grief
- _____ Feeling sadness or depression related to grief
- _____ Gender identity concern
- _____ Health concerns (physical complaints and/or medical problems, chronic illness)
- _____ Non-family relationship problems (friends, significant other, etc.)
- _____ Parent-child relationship (discipline, single parent, etc.)
- _____ Personal growth
- _____ Religious or spiritual concerns
- _____ Sexual concerns
- _____ Sexual identity concerns
- _____ Sleep problems (nightmares, sleeping too much or too little, etc.)
- _____ Suicidal ideation (thoughts of death, wanting to die)
- _____ Unusual experiences (loss of periods of time, sensing unreal things, etc.)
- _____ Other (please explain) _____

****Remember to circle the most significant issue.****



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When did you first become concerned about this/these issue(s)? _____
 How have you attempted before now to deal with this/these issue(s)?

Other treatment you have received to address any of the concerns indicated above:

None _____ Individual Counseling _____ Family Counseling _____
 Group Counseling _____ Hospitalization _____ Other _____
 Spiritual Counseling _____ Healer _____

HISTORICAL EXPERIENCES

(For each of the following items that apply, write in your approximate age at the time it occurred):

Raised by:

Natural parents _____ Single natural parent _____ Natural & step-parent _____
 Adoptive parents _____ Relatives _____ Foster parents _____
 Grandparents _____ Institution _____ Other _____

Please describe your father (or male figure who raised you).

Please describe your mother (or female figure who raised you).

Please list your siblings, ages, and your relationship with them as a child and as an adult.

Have you ever been abused (check all that apply):

Physically _____ Emotionally _____ Sexually _____ Spiritually _____

Have you ever been neglected (check all that apply): Physically _____ Emotionally _____



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Stressors in the family:

Chronic illness of family member _____ Death of significant person _____
 Domestic violence _____ Parents arguing frequently _____
 Family member absent (explain) _____
 Family member's disability/major accident/illness _____
 Family member's emotional/mental health problems (explain) _____

Family member suicide (explain) _____
 Financial problems _____ Parents divorced _____
 Moved a lot _____ Other _____

History of concerns including recent changes in any of the following: (check all that apply)

Appetite change _____	Hearing voices _____	Suicidal thoughts _____
Emotional problems _____	Loss of energy or fatigue _____	Suicide attempts _____
Gained weight _____	Lost weight _____	Paranoia _____
Accident-prone _____	Aggressive behavior (explain) _____	
Alcohol/drug use _____	Attention problems _____	Frequent arguments _____
Hyperactive _____	Impulsive _____	Loner _____
Taken advantage of _____	Temper outbursts _____	Irritable _____
Obsessive worrying _____	Easily startled _____	Phobias _____
Keyed up, on edge _____	Asthma _____	Disability _____
Nervous stomach _____	Reading minds _____	Dizziness _____
Neurological problems _____	Bone/joint/muscle _____	Headache (kind) _____
PMS _____	Chest pain _____	Heart palpitations _____
Serious overeating _____	Undereating _____	Chronic illness _____
Hospitalization _____	Shortness of breath without exertion _____	
Major accident _____	Sleep problem _____	Diarrhea _____
Developmental delay(s) _____	Major illness _____	Surgeries _____
Death of pet(s) _____	Death of significant other _____	Natural disaster _____
Incarcerated family member _____	Medical treatment _____	Sexual assault _____
Witnessed violence or death _____	Victim of trauma (unusual, terrifying experience) _____	
Other _____		

Support System (such as church, friends, family, relatives, school, etc.)

Hardly any support 1 2 3 4 5 Considerable support

Please list who is in your support system



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What are your interests?

How were you referred to Healing Sounds Music Therapy? _____

May we thank your referral source? Yes No

If yes, contact information:

I, _____, certify that all information stated in this form is correct and honest to the best of my knowledge. I have not intentionally lied or misrepresented myself in any way.

Client Signature

Date