TIANA DICK, BM, MTA, MT-BC
Board Certified Music Therapist

CLIENT NAME:	CLIENT #:
MUSICAL:	
WHAT IS THE CLIENT'S FAVOURITE STYLE/GENRE OF MUSIC?	
DOES THE CLIENT HAVE A FAVOURITE ARTIST OR SONG/SONGS?	
DOES THE CLIENT KNOW SPECIFIC TRADITIONAL CHILDREN'S SONGS? PLEASE LIST.	
ARE THERE ANY INSTRUMENTS THE CLIENT IS TYPICALLY DRAWN TO?	
HOW DOES THE CLIENT RESPOND TO MUSIC? (DANCE, SING, MOVE, PLAY AN INSTRUMENT)	
DOES THE CLIENT DISPLAY ANY PARTICULAR MUSICAL APTITUDE?	
ACADEMIC:	
DOES THE CLIENT ATTEND SCHOOL?	HOMESCHOOLED?
NAME OF SCHOOL:	DISTRICT:
TEACHER'S NAME:	TYPE OF CLASSROOM:
TEACHER'S EMAIL:	
IS THE CLIENT ON A MODIFIED PROGRAM?	
DOES THE CLIENT HAVE AN IEP OR IHP?	

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ACADEMIC CONT.		
DOES THE CLIENT WORK WITH AN AIDE?		
DOES THE CLIENT MATCH COLOURS?		
IS THE CLIENT COLOURBLIND?		
DOES THE CLIENT READ?	WRITE?	
IF SO, AT WHAT LEVEL?		
DOES THE CLIENT WRITE INDEPENDENTLY?	LEFT HANDED	RIGHT HANDED
DOES THE CLIENT USE A WRITTEN SCHEDULE?		
DOES THE CLIENT HAVE DIFFICULTY MAINTAINING ATTENTION TO DIRECTIONS AND TASKS?		
IF SO, PLEASE DESCRIBE.		

SOCIAL:
PLEASE DESCRIBE THE CLIENT'S SOCIAL SKILLS WITH FRIEND/PEER GROUP?
PLEASE DESCRIBE THE CLIENTS SOCIAL SKILLS WITH FAMILY?
PLEASE DESCRIBE THE CLIENT'S SOCIAL SKILLS WITH PERSONS IN AUTHORITY?
DOES THE CLIENT INTERACT WELL ON A ONE-TO-ONE BASIS?
DOES THE CLIENT HAVE ANY SPECIAL SKILLS, HOBBIES OR INTERESTS?
DOES THE CLIENT PARTICIPATE APPROPRIATELY IN GROUP ACTIVITIES?

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SENSORY:
HAS THE CLIENT BEEN DIAGNOSED WITH ANY DEGREE OF HEARING LOSS? IF SO, PLEASE DESCRIBE.
DOES THE CLIENT HAVE A HISTORY OF EAR INFECTIONS?
DOES THE CLIENT WEAR A HEARING AID?
DOES THE CLIENT HAVE A COCHLEAR IMPLANT?
HAS THE CLIENT BEEN DIAGNOSED WITH ANY FORM OF VISION LOSS? IF SO, PLEASE DESCRIBE.
DOES THE CLIENT HAVE ANY SENSORY PROCESSING ISSUES? IF SO , CHECK ALL THAT APPLY. TACTILE DEFENSIVENESS /TACTILE SEEKING (RELATED TO TOUCH) VESTIBULAR DYSFUNCTION: AWARENESS OF BODY IN SPACE PROPRIOCEPTIVE DYSFUNCTION: PLANNING AND MAINTAINING MOVEMENT AUDITORY SENSITIVITY /LACK OF SENSITIVITY TO SOUND OTHER:
PLEASE EXPLAIN.
EMOTIONAL:
WHAT IS THE CLIENT'S FAVOURITE ACTIVITY?
WHAT TYPICALLY CALMS/SOOTHES THE CHILD/CLIENT?
IS THE CLIENT CURRENTLY ENROLLED IN ANY COMMUNITY BASED ACTIVITIES, SPORTS OR GROUPS?
IS THERE ANYTHING ELSE YOU WOULD LIKE ME TO KNOW ABOUT YOUR CHILD/THE CLIENT?
DOES THE CLIENT DISPLAY EMOTIONS APPROPRIATELY?
DOES THE CLIENT EXPERIENCE ANXIETY? IF SO, WHAT ARE THE TRIGGERS I SHOULD BE AWARE OF?

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DOES THE CLIENT HAVE ANY BEHAVIORAL DIFFICULTIES I SHOULD BE AWARE OF?
HAS THE CLIENT SUFFERED ANY EMOTIONAL TRAUMA OR RECENT CHANGES IN LIFE CIRCUMSTANCES?
HOW WOULD YOU DESCRIBE YOUR CHILD'S/THE CLIENT'S LEVEL OF SELF ESTEEM?
MOTOR:
DOES THE CLIENT HAVE ANY GROSS MOTOR DIFFICULTIES?
IS THE CLIENT FULLY AMBULATORY?
DOES THE CLIENT HAVE FULL USE OF ALL HIS/HER/THEIR LIMBS? IF NOT, PLEASE DESCRIBE.
DOES THE CLIENT HAVE ANY FINE MOTOR DIFFICULTIES?
IS THE CLIENT ABLE TO PERFORM FINE MOTOR TASKS WITH BOTH HANDS?
DOES THE CLIENT FREQUENTLY DROP OR HAVE DIFFICULTY HOLDING OBJECTS?
HAS THE CLIENT BEEN DIAGNOSED WITH HIGH OR LOW MUSCLE TONE? IF SO, PLEASE DESCRIBE.
DOES THE CLIENT USE THE RESTROOM INDEPENDENTLY?
COMMUNICATION:
DOES THE CLIENT HAVE ANY SPEECH OR LANGUAGE DIFFICULTIES? IF YES, PLEASE DESCRIBE.
DOES THE CLIENT COMMUNICATE VERBALLY?
DO OTHER'S UNDERSTAND THE CLIENT'S SPEECH?
DOES THE CLIENT SPEAK IN COMPLETE SENTENCES?

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DOES THE CLIENT ASK AND ANSWER QUESTIONS?
DOES THE CLIENT MAKE INDEPENDENT COMMENTS?
DOES THE CLIENT ENGAGE IN BACK AND FORTH CONVERSATIONS?
DOES THE CLIENT COMMUNICATE USING SIGN LANGUAGE?
DOES THE CLIENT USE ANY DEVICES TO AID IN COMMUNICATION? IF SO, PLEASE DESCRIBE.

ADDITIONAL COMMENTS:

SIGNATURE OF PARENT OR GUARDIAN:	DATE:

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