HEALING SOUNDS
MUSIC THERAPY

HEALING SOUNDS
Stephanie Bolton, MA, MT-BC
Phone: 256-655-0648
E-mail: stephanie@imageryandmusic.com

Improving personal health and wellness through imagery and music

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 Trans Other 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.)

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.)

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? _____

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

History of alcohol/drug/substance abuse: Yes No

History of domestic violence: Yes No

History of violence in family of origin: Yes No

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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 <u>are now</u> receiving <u>or have</u> 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 _____

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

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 _____

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

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

What are your interests/hobbies?
_____
_____
_____
_____

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