Pentatonic Therapies
MUSIC THERAPY OF MACON, GA

New Patient Intake Form
Adult

Client Information:

Client's Name (as it appears on insurance card):_____ DOB:_____ M or F Date:_____

Billing Address:_____ City:_____ State:_____ Zip:_____

Services Performed Address:_____ City:_____ State:____ Zip:_____

Phone Number:_____ Cell Phone Number:_____

Email:_____ Education achieved:_____

Occupation:_____ Hours Worked Per Week _____

Diagnosis (if applicable): _____

Caregiver's Information (If applicable): ☐ *Not Applicable*

Caregiver's Name:_____ Relationship to Client:_____

Phone Number:_____ Cell Phone Number:_____

Email:_____

Client's Family Background:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐Partnership

Lives with: ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐Alone

Do you have children? ☐Yes ☐No If yes, please list their names below:

_____

_____

Emergency Contact Name:_____ Relationship: _____

Emergency Contact Phone Number: 1-_____ 2-_____

Primary Physician Name:_____ Phone Number:_____

Address: _____ City:_____ State:_____ Zip:_____

Referring Physician (if different)_____

Other doctors and specialist involved in client's care:

Name	Specialty	Phone Number

Insurance Information:

____ I decline the use of my insurance and will pay out of pocket at the time of service

Primary Insurance:_____ Name of insured:_____

Insured SS#:_____-_____-_____ Member ID:_____ Group :_____

Claims Address (found on back of card):_____

City:_____ State:_____ Zip:_____ Customer Service Number:_____

Secondary Insurance:_____ Name of Insured:_____

Member ID:_____ Group #:_____

Claims Address (found on back of card):_____

City:_____ State:_____ Zip:_____ Customer Service Number:_____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the therapist has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting our understanding of your personal case. Your time, thoughtfulness and honesty in completing this overview will greatly aid us in addressing your health needs.

Family History:

Do you or anyone in your family have a history of any of the following? (Please circle and note who)

☐ Cancer	☐ Diabetes	☐ Heart Disease	☐ High Blood Pressure	☐ Kidney Disease
☐ Epilepsy	☐ Arthritis	☐ Glaucoma	☐ Tuberculosis	☐ Stroke
☐ Anemia	☐ Mental Illness	☐ Asthma	☐ Hay Fever	☐ Hives

Any other relevant family history: _____

What is your family heritage? _____

Do you have a religious or spiritual practice? ☐ Yes ☐No

If Yes, what kind_____

Please circle whether you had any of the following as a child:

Rheumatic Fever	Diphtheria	Scarlet Fever	Chicken Pox
German Measles	Measles	Mumps	Congenital Heart Defect

General Information:

Height: _____ Weight: _____

When is your energy level best during the day? _____ Worst: _____

Current Medications:

Please list any prescription medications, vitamins or other supplements you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Allergies:

Are you hypersensitive or allergic to:

Any drugs: _____

Any foods: _____

Any environmental or chemical allergies: _____

Typical Food Intake:

Breakfast: _____

Lunch: _____

Supper: _____

Snacks: _____

Hospitalization/Surgery/Imaging:

What hospitalizations, surgeries, x-rays, CAT scans, EEGs, EKGs have you had?

Event	Year	Event	Year

Why did you choose music therapy? _____

_____

_____

What three expectations do you have for therapy? _____

_____

_____

What do you love to do/What are your hobbies? _____

_____

_____

What is your favorite style of music/ What are your favorite songs? _____

_____

_____

Are there any instruments or types of music you dislike? _____

_____

_____

Is there any additional information you would like to share? _____

_____

_____

FOR THE FOLLOWING, PLEASE CIRCLE:

Y = Yes/condition you have NOW **N** = No/never had **P** = Problem in the past **S** = Sometimes a problem now

General:

Do you sleep well? Y N P S
Awake rested? Y N P S
Have a supportive relationship? Y N P S
Have a history of abuse? Y N P S
Experienced a major trauma? Y N P S
Take vacations? Y N P S
Spend time outside? Y N P S
Eat three meals a day? Y N P S

Neurologic:

Seizures? Y N P S
Muscle weakness? Y N P S
Vertigo or dizziness? Y N P S
Paralysis? Y N P S
Numbness or tingling? Y N P S
Easily stressed? Y N P S
Loss of balance? Y N P S

Immune:

Chronically swollen glands? Y N P S
Slow wound healing? Y N P S
Chronic infections? Y N P S

Endocrine:

Hypothyroid? Y N P S
Hypoglycemic? (low blood pressure) Y N P S
Excessive thirst? Y N P S
Fatigue? Y N P S
Heat or cold intolerance? Y N P S
Hyperthyroid? Y N P S
Diabetes? Y N P S
Excessive hunger? Y N P S
Seasonal depression? Y N P S
Difficulty exercising? Y N P S

Ears:

Impaired hearing?	Y	N	P	S
Ringing in ears?	Y	N	P	S
Dizziness?	Y	N	P	S
Earaches?	Y	N	P	S

Eyes:

Impaired vision?	Y	N	P	S
Cataracts?	Y	N	P	S
Spots in vision?	Y	N	P	S
Color blindness?	Y	N	P	S
Tearing or dryness?	Y	N	P	S
Eye pain or strain?	Y	N	P	S

Head:

Headaches?	Y	N	P	S
Migraines?	Y	N	P	S
Head injury?	Y	N	P	S
Jaw or TMJ problems?	Y	N	P	S

Nose and Sinus:

Frequent colds?	Y	N	P	S
Stuffiness?	Y	N	P	S
Sinus problems?	Y	N	P	S
Nose bleeds?	Y	N	P	S
Hay fever?	Y	N	P	S
Loss of smell?	Y	N	P	S

Neck:

Lumps in neck?	Y	N	P	S
Difficulty swallowing?	Y	N	P	S
Pain or stiffness in neck?	Y	N	P	S

Mouth and Throat:

Frequent sore throat?	Y	N	P	S
Copious saliva?	Y	N	P	S
Sore tongue or lips?	Y	N	P	S
Hoarseness?	Y	N	P	S
Jaw clicks?	Y	N	P	S
Teeth grinding?	Y	N	P	S

Skin:

Rashes?	Y	N	P	S
Change in skin color?	Y	N	P	S
Lumps or bumps on skin?	Y	N	P	S
Eczema or hives?	Y	N	P	S
Itching?	Y	N	P	S

Respiratory:

Cough?	Y	N	P	S
Asthma?	Y	N	P	S
Wheezing?	Y	N	P	S
Bronchitis?	Y	N	P	S
Coughing up blood?	Y	N	P	S
Shortness of breath?	Y	N	P	S
Shortness of breath when lying down?	Y	N	P	S
Pain in breathing?	Y	N	P	S
Emphysema?	Y	N	P	S
Tuberculosis?	Y	N	P	S

Gastrointestinal:

Trouble swallowing?	Y	N	P	S
Change in thirst?	Y	N	P	S
Change in appetite?	Y	N	P	S
Nausea/Vomiting?	Y	N	P	S
Ulcer?	Y	N	P	S
Jaundice?	Y	N	P	S
Heartburn?	Y	N	P	S
Abdominal pain or cramps?	Y	N	P	S

Mental/Emotional:

Treated for emotional problems?	Y	N	P	S
Depression?	Y	N	P	S
Anxiety of nervousness?	Y	N	P	S
Poor concentration?	Y	N	P	S
Mood swings?	Y	N	P	S
Have you considered suicide?	Y	N	P	S
Attempted suicide?	Y	N	P	S

Tension?	Y N P S	Muscle spasms or cramps?	Y N P S
Memory problems?	Y N P S	Sciatica?	Y N P S
Excessive crying?	Y N P S		
Excessive anger or outbursts?	Y N P S	**Cardiovascular:**	
		Chest pain or angina?	Y N P S
Musculoskeletal:		Palpitations (episodic	Y N P S
Joint pain or stiffness?	Y N P S	fast heart beat)?	
Arthritis?	Y N P S	High blood pressure?	Y N P S
Broken bones?	Y N P S	Edema or swelling?	Y N P S
Weakness?	Y N P S	Difficulty breathing?	Y N P S

How did you hear about Pentatonic Therapies? _____

Consent to Treat

I, _____ consent for Pentatonic Therapies, LLC to provide me with Music Therapy services. I consent to care and treatment falling under the practice guidelines of the Certification Board of Music Therapist (CBMT) and the State of Georgia. I acknowledge that there is always a risk of injury with any therapy involving physical activities and equipment. Pentatonic Therapies, LLC is NOT responsible for any injury associated with equipment use when not in the company of the treating therapist. You are responsible for making your therapist aware of any changes to your physical or mental condition. Pentatonic Therapies, LLC is a teaching facility and supervised students and volunteers may participate in your treatment session. If under guardianship, an in-home caregiver or guardian must be present at the time of treatment.

_____ _____

Patient/Caregiver Date

Attendance Policy

Your child's progress depends on your family's commitment to therapy. When you schedule an appointment with Pentatonic Therapies, you are "reserving" that time. Therefore, we must adhere to the following strict cancellation policy. Pentatonic Therapies' policy states that we require a 24-hour notice for cancellations. For land-based services, after a one-time courtesy occurrence, a **$50 cancellation fee will be charged for EACH missed therapy appointment. Please note that insurance cannot be billed for this fee and you will be personally responsible for this charge.** Pentatonic Therapies will consider waiving this charge if you are able to **reschedule your missed appointment**. **PLEASE ENSURE YOU INFORM PENTATONIC THERAPIES OF SCHEDULE CHANGES DURING HOLIDAYS, SCHOOL BREAKS AND SUMMER BREAKS**. If attendance becomes an issue and you are not able to make your appointments, understand that we will need to discuss other options as we may not be able to hold your slot.

Pentatonic Therapies works with medically fragile children and does not want to carry sickness to other families, infect ourselves, or our own families. Please be respectful and cancel your therapy appointment if your child is sick. You will not be a charged a cancellation fee for sickness and we will work to reschedule your appointment when your child is healthy. The Board of Health considers the following signs to indicate communicable disease/illness**: vomiting, fever over 100 degrees, diarrhea, sore throat, rash/swelling, red, or running eyes**. Please be sure your child is symptom free for 24 hours before resuming therapy.

Pentatonic Therapies' time is very valuable, and the duration of therapy sessions are catered to your child's needs. Please be available or arrive on time for your appointment.

Parent/Legal Guardian Signature_____Date:_____