Pentatonic Therapies
MUSIC THERAPY OF MACON, GA

New Patient Intake Form
Pediatric

Client Information:

Client's Name (as it appears on insurance card):_____ DOB:_____ M or F Date:_____
Parents'/Guardians' Names:_____
Address:_____ City:_____ State:_____ Zip:_____

Please check preferred communication

☐ Phone Number:_____ ☐ Cell Phone Number:_____
☐ Email:_____

Emergency Contact Name:_____
Emergency Contact Phone Number: 1-_____ 2-_____

Client's Diagnosis (If known):_____

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:_____

Medicaid Number:_____ Effective Date:_____

Family Background:

Mother's Name: _____ DOB:_____ Occupation:_____

Father's Name:_____ DOB:_____ Occupation:_____

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

Who does the child live with? _____

Does your child have siblings? ☐ Yes ☐ No If Yes, names and ages of siblings: _____

_____

Religious Preference:_____ Parent's preferred music:_____

What do you wish to achieve for your child through therapy? _____

_____

_____

Is your child ***currently*** receiving therapy services? ☐ Yes ☐No

If "YES", where and duration? _____

Has your child ***previously*** received therapy services? ☐ Yes ☐No

if "YES", where and when? _____

Any additional information you would like to share:_____

_____

_____

_____

Medical History:

At how many weeks was your child born? _____ Birth Weight: _____ Circle One: Vaginal or C-Sections

Were there any complications during pregnancy or delivery? ☐ Yes ☐ No

If "YES", please describe: _____

Was your hospitalized after birth? ☐ Yes ☐ No

Please list any hospitalizations and/or medical procedures: _____

_____

_____

Any additional significant **family** history: _____

_____

_____

Allergies:

Please list all known allergies that your child has:	Reaction:
1	1
2	2
3	3
4	4

Current medications:

Name:	Dosage:	Frequency:	Reason for medication:

Gross motor:

- Have you noticed that the child has any gross motor difficulties? ☐Yes ☐No
- Is your child fully ambulatory? ☐Yes ☐No
- Does your child require any physical assistance? ☐Yes ☐No
- Does your child have full use of all of his/her limbs? ☐Yes ☐No

Fine motor:

- Have you noticed that your child has any fine motor difficulties? ☐Yes ☐No
- Is your child able to perform fine motor tasks with both hands? (i.e. eat with utensils, button a button, hold a pencil) ☐Yes ☐No
- Does your child frequently drop items or have difficulty holding objects? ☐Yes ☐No

Oral:

- Does the child have any feeding issues? ☐Yes ☐ No
- Does the child have any respiratory issues? ☐Yes ☐No

Sensory:

- Have you noticed that your child has any sensory issues? ☐Yes ☐ No
- Does your child resist physical support? ☐Yes ☐No
- Does your child engage in any repetitive behaviors? ☐Yes ☐No
- Does your child have any deficits in hearing, vision, or other senses? ☐Yes ☐No
- Does your child have any sensitivities to/or extreme preferences for particular sounds? ☐Yes ☐No
- Is your child over-stimulated by sounds, lights, or crowds? ☐Yes ☐No

Receptive communication/auditory perception:

- Has your child been diagnosed with any hearing difficulties? ☐Yes ☐No
  If so, has an audiogram been done and what were results: ☐Yes ☐No
- Does your child have difficulty hearing sounds or understanding speech? ☐Yes ☐No
- Does your child have a history of ear infections? ☐Yes ☐No
- Does your child understand or react to what is being said to him/her? ☐Yes ☐No

Expressive communication:

- Have you noticed that your child has any speech or language difficulties? ☐Yes ☐No
- Does your child communicate verbally? ☐Yes ☐No
  If not, please indicate mode of communication: ☐Yes ☐No
- Do others easily understand your child? ☐Yes ☐No
- Does your child have any idiosyncratic (peculiar or unique) speech? ☐Yes ☐No

Cognitive:

- Have you noticed that your child has any cognitive deficits or difficulties? ☐Yes ☐No
- Does your child have an IEP (Individualized Education Plan)? ☐Yes ☐No
- Is your child in with same-age peers in their educational setting? ☐Yes ☐No

Emotional:

- Have you noticed that your child has any emotional difficulties? ☐Yes ☐No
- Does your child show emotions appropriately? ☐Yes ☐No
- Does your child tantrum or get angry easily? ☐Yes ☐No
- Has your child suffered any emotional trauma or recent change in life circumstances? ☐Yes ☐No

Social:

- Have you noticed that the child has any social difficulties? ☐Yes ☐No
- Does your child have any difficulty relating to family members? ☐Yes ☐No
- Does your child have a social group of like-aged peers? ☐Yes ☐No
  If "Yes", where/who:_____
- Does your child participate in conversation or play with others? ☐Yes ☐No
- Does your child have any particular difficulties in school or other social situations? ☐Yes ☐No
- If "Yes", please explain:_____

Does your child have any medical issues or concerns? ☐ Yes ☐ No

If "YES", please describe: _____

_____

Additional Information:

Favorite Songs: _____

_____

Favorite toys/activities: _____

_____

How did you hear about Pentatonic Therapies? _____

_____ _____ _____

Name of Person Completing This Form **Relationship to Child** **Date**

Consent to Treat

I, _____ consent for Pentatonic Therapies to provide my child, _____ with Music Therapy services. I consent to care and treatment falling under the practice guideline 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 is NOT responsible for any injury associated with equipment use when your child is not with a treating therapist. You are responsible for making your therapist aware of any changes to your child's physical or mental condition. Pentatonic Therapies is a teaching facility and supervised students and volunteers may participate in your child's treatment session.

_____ _____

Parent/Legal Guardian **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:_____