Music Therapy Intake Form

Please fill out this form to the best of your ability- Thank you!

Today's Date:	
Name of Person Completing Form:	**Relationship to Child:**
Child's Name:	**Birth Date**:
Preferred Name:	**Male/Female (please circle)**
Parent/Caregiver 1: Relation to child:	**Phone Number**:
Parent/Caregiver 2: Relation to child:	**Phone Number**:
Address:	**Email:**
Please select preferred method of communication ❑ **Phone Number** ❑ **Cell Phone Number** ❑ **E-mail**	
Child lives with: ❑ Both Parents ❑ Mother ❑ Father ❑ Grandparents ❑ Other:	**Are there any guardianship/custody issues our office should be aware of?** ❑ **Yes** ❑ **No**

	If yes, please explain:
Primary Language Spoken in the Home:	
Does your child have siblings?	❑ **Yes** ❑ **No**
Please List Name & Ages of Siblings:	
	❑ **Yes** ❑ **No**
Adoption Background:	
How did you hear about Chatterbox Pediatric Therapy?	

MEDICAL BACKGROUND
Primary Care Physician:
Please list any other doctors and specialists who are involved in your child's care:
Please list any hospitalizations and/or medical procedures or significant family history
Current medications Name Dosage Frequency Reason for medication

Please list any medical diagnoses
Is your child on a special diet?

BIRTH & DEVELOPMENTAL HISTORY	
Was your child carried to full term?	❑ **Yes** ❑ **No**
If not, how many weeks early was your child born?	
Birth weight:	
Was your child hospitalized after birth?	❑ **Yes** ❑ **No**
Vaginal or C-section?	
If there were any complications during the pregnancy or delivery, please provide that information here:	
Please list corresponding age for which your child reached each milestone:	
Rolling	
Sitting	
Crawling	
Walking	
First words	
First Sentence	
Did your child ever experience periods of regression?	❑ **Yes** ❑ **No**
If yes, please explain:	

Are there any precautions we should take in working with your child?	❑ **Yes** ❑ **No**
If yes, please explain here: (i.e. seizures, biting, self-injurious behavior, etc.)	

EDUCATIONAL & THERAPY BACKGROUND	
Does your child currently receive other therapy services?	❑ **Yes** ❑ **No**
If "Yes", please check which types: ❑ Speech Therapy ❑ Occupational Therapy ❑ Physical Therapy ❑ ABA ❑ Counseling ❑ Other:	
If yes, please list name and location where therapy services are currently received:	
Does your child currently attend school?	❑ **Yes** ❑ **No**
If yes, please list name of school:	
What grade is your child in?	
Does your child have a current Individualized Education Plan (IEP) or IFSP?	❑ **Yes** ❑ **No**
If yes, what services are received through the IEP/IFSP?	

MUSIC THERAPY QUESTIONAIRRE	
Has your child previously received Music Therapy before:	❑ **Yes**

	❑ **No**
If yes, please list when & where:	
Are there any musicians in your family?	❑ **Yes** ❑ **No**
If yes, who?	
Has your child had any previous musical experience or exposure?	❑ **Yes** ❑ **No**
If yes, please explain:	
Do you believe your child has any musical aptitude?	❑ **Yes** ❑ **No**
If yes, please explain:	
What are your child's favorite toys/activities?	
Who are your child's favorite musicians?	
What are your child's favorite songs?	
What typically calms/soothes your child?	
Who does your child spend most of their time with?	
Is your child currently enrolled in any community activities (music class, sports programs, church/youth group, play groups, Mother's Morning Out Program)?	
Is there anything we have not covered that you feel is important to share with us?	

Special Needs or Areas of Concern

Gross Motor

Does your child have any gross motor difficulties? If yes, please briefly explain.	❑ **Yes** ❑ **No**
Is your child fully ambulatory?	❑ **Yes** ❑ **No**
Does your child require any physical assistance?	❑ **Yes** ❑ **No**
If yes, please explain:	
Does your child fully use all his/her limbs?	❑ **Yes** ❑ **No**
If not, please note any limitations.	

Fine Motor

Does your child have 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 Motor

Does your child have any feeding issues?	❑ **Yes**

	❑ **No**
If yes, please explain.	
Does your child have any respiratory issues? If yes, please explain.	❑ **Yes** ❑ **No**

Sensory

Does your child have any sensory sensitivities or sensory processing issues?	❑ **Yes** ❑ **No**
If yes, please explain	
Does your child resist physical support?	❑ **Yes** ❑ **No**
If yes, please explain	
Does your child engage in any repetitive behaviors?	❑ **Yes** ❑ **No**
If yes, please explain	
Does your child have any deficits in vision, hearing or any other senses?	❑ **Yes** ❑ **No**
If yes, please explain	
Does your child have any sensitivities to/or extreme preferences for particular sounds?	❑ **Yes** ❑ **No**
If yes, please explain	

Receptive communication/auditory perception

Has your child been diagnosed with any hearing difficulties?	❑ **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/react to what is being said to him/her?	❑ **Yes** ❑ **No**

Expressive communication

Does your child have any speech or language difficulties?	❑ **Yes** ❑ **No**
Does your child communicate verbally?	❑ **Yes** ❑ **No**
If no, how do they communicate their wants and needs? (i.e. gestures, signs, vocalizations, AAC)	
Do others easily understand your child?	❑ **Yes** ❑ **No**
Does your child sing along to music?	❑ **Yes** ❑ **No**

Cognitive

Does your child have any cognitive deficits or difficulties?	❑ **Yes** ❑ **No**
Is your child with same-aged peers in the educational setting?	❑ **Yes** ❑ **No**

Emotional

Does your child have any emotional difficulties?	❑ **Yes** ❑ **No**
Does your child show emotions appropriately?	❑ **Yes** ❑ **No**
Does your child tantrum or get upset easily?	❑ **Yes** ❑ **No**
Has your child suffered any emotional trauma or recent hange in life circumstances?	❑ **Yes** ❑ **No**

Social

Does your child have any challenges in social interactions?	❑ **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**
Does your child participate in conversation or play with others?	❑ **Yes** ❑ **No**
Does your child have difficulties in school or other social situations?	❑ **Yes** ❑ **No**

I attest that all the above information is true and accurate to the best of my knowledge.

Name:	
Date:	
Relationship to Child:	

FINANCIAL INFORMATION

The following information explains our billing and financial policy for music therapy services. Please contact us at 912-988-1526 with questions about billing/payments.

Most commercial insurance will not pay for music therapy services; however, our billing staff would be happy to assist you with verifying out of network benefits. Please note that a medical referral from your physician deeming music therapy as a medically necessary service may be required to file for out of network coverage. (Aetna, Cigna, UHC most likely to have some OON benefits).

Chatterbox Pediatric Therapy, LLC is not a Medicaid provider for music therapy services.

Music therapy may be considered a qualifying medical expense for Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs). You may also seek reimbursement from your HSA or FSA after paying out of pocket for music therapy services. However, it is ultimately up to your specific HSA or FSA provider to approve payment or reimbursement for services.

Alternative funding sources include the NOW/COMP Waiver, Family Supports Funding

Private Pay rates are also available

Please select how you will be paying for music therapy services:

- ❑ Private Pay (Must have a credit card on file)
- ❑ Out of Network Benefits (Patient pays private rate, we will provide you with information to file with your insurance company to apply to OON Benefits, if any)
- ❑ Medicaid Waiver (Now/COMP)
- ❑ Family Supports Funding*

By signing below, I acknowledge understanding that I am financially responsible for all charges accrued for music therapy services provided through Chatterbox Pediatric Therapy. I understand that Chatterbox is Out of Network (OON) for Music Therapy services with all commercial insurance plans. Should I choose to file for OON benefits through my insurance company, I am responsible for paying all charges for services and will then submit for reimbursement from my insurance company.

I also understand that funding obtained through the Now/COMP waiver or Family Supports Funding is not a guarantee of payment for Music Therapy services. Any balance that is not paid by alternative funding sources will be my responsibility to pay within 30 days of balance accrual.

Patient or guardian signature: _____ Date: _____

Please complete the information below if you will be using Medicaid Waiver or Family Supports Funding

WAIVERS:		
Are you approved for any Waivers (NOW/COMP)?	Yes	No
If so, what is the name of your waiver case manager? Email: Phone:		
Are your waiver funds self- directed or managed by a company?		
If managed by a company, please list name of Agency and Address		

FAMILY SUPPORTS FUNDING:		
Have you been approved for Family Supports Funding?	Yes	No
Are these funds specifically to be used for therapy services?	Yes	No
Are these funds currently being used towards other therapy services?	Yes	No