Axon Music Therapy

Background Information Form

Clients Name: _____

Referred by: _____

Personality Characteristics:

_____

_____

Client Interests/Hobbies:

_____

_____

Diagnosis(es):

_____

_____

Medications:

_____

_____

History of Treatment:

_____

_____

Music Preferences:

Previous Musical Experience:

Previous Reports and Assessments:

Current general goal areas (e.g. motor coordination, speech clarity):

Specific functional goals (e.g. producing specific vowel sound, being able to type):

Reasons for Interest in Music Therapy:

Other comments: