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 Canadian Association of Music Therapists (certified member)  
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**SUPERVISOR:**

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Date: \_\_\_\_\_

**INTAKE FORM**

PERSONAL INFORMATION:	
Name:	
Gender:	
Age:	
Birth Date:	
Education:	
Occupation:	
Home Address:	
Email Address:	

May we contact you by email? YES NO

Phone #:	Home #:	Work #:	Cell #:
Emergency Contact Person:	Name:	Relationship:	Phone #:

May we contact you by phone? YES NO

May we leave a message on your voicemail? YES NO

Where did you see my name? \_\_\_\_\_

<b>FAMILY INFORMATION:</b>					
<b>NAME:</b>	<b>GENDER:</b>	<b>AGE:</b>	<b>BIRTH DATE:</b>	<b>EDUCATION:</b>	<b>OCCUPATION:</b>
<b>Spouse/Partner:</b>					
<b>Children/Step-children/ Siblings:</b>					
1.					
2.					
3.					
4.					

<b>MEDICAL INFORMATION:</b>	
<b>Family Physician:</b>	

<b>Describe any health problems or serious illnesses (past or current):</b>		
<b>What medications do you take (including supplements and vitamins)?</b>		
<b>List any prior surgeries:</b>		
<b>If you had prior counselling or therapy:</b>		
When?	What was the concern?	Who was your counsellor?
<b>If you ever been hospitalized for psychiatric treatment:</b>		
When?	Where?	How long?

**What brings you to psychotherapy now? How long have your current problems existed?**

**Describe your present concerns (circle one):**

Mild    Moderate    Moderately Severe    Severe    A Crisis

**PLEASE MARK ALL THAT APPLY:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> crying spells            | <input type="checkbox"/> depressed               | <input type="checkbox"/> "no one understands me"   |
| <input type="checkbox"/> fast heartbeat           | <input type="checkbox"/> cold feet and hands     | <input type="checkbox"/> headaches                 |
| <input type="checkbox"/> money problems           | <input type="checkbox"/> problems with children  | <input type="checkbox"/> quick-tempered            |
| <input type="checkbox"/> unable to have fun       | <input type="checkbox"/> trouble sleeping        | <input type="checkbox"/> worried about health      |
| <input type="checkbox"/> always worried           | <input type="checkbox"/> feeling panicky         | <input type="checkbox"/> fainting spells           |
| <input type="checkbox"/> relationship concerns    | <input type="checkbox"/> problems with parents   | <input type="checkbox"/> impatient with people     |
| <input type="checkbox"/> feelings easily hurt     | <input type="checkbox"/> feeling lonely          | <input type="checkbox"/> can't concentrate         |
| <input type="checkbox"/> frequent sweating        | <input type="checkbox"/> diarrhea                | <input type="checkbox"/> unable to relax           |
| <input type="checkbox"/> work difficulties        | <input type="checkbox"/> poor physical health    | <input type="checkbox"/> binge eating              |
| <input type="checkbox"/> lacking in confidence    | <input type="checkbox"/> loss of weight          | <input type="checkbox"/> can't 'get going'         |
| <input type="checkbox"/> dizziness                | <input type="checkbox"/> shy with people         | <input type="checkbox"/> feeling fearful           |
| <input type="checkbox"/> sexual problems          | <input type="checkbox"/> fighting and quarreling | <input type="checkbox"/> very restless             |
| <input type="checkbox"/> constipation             | <input type="checkbox"/> not enjoying things     | <input type="checkbox"/> feeling angry             |
| <input type="checkbox"/> shaky limbs              | <input type="checkbox"/> muscle twitching        | <input type="checkbox"/> overly sensitive          |
| <input type="checkbox"/> can't hold a job         | <input type="checkbox"/> dislike my body         | <input type="checkbox"/> don't like being alone    |
| <input type="checkbox"/> feeling grouchy          | <input type="checkbox"/> suicidal thoughts       | <input type="checkbox"/> feel like hurting someone |
| <input type="checkbox"/> stomach trouble          | <input type="checkbox"/> nausea or vomiting      | <input type="checkbox"/> anxious inside            |
| <input type="checkbox"/> excessive drinking       | <input type="checkbox"/> full of energy          | <input type="checkbox"/> lack energy               |
| <input type="checkbox"/> always tired             | <input type="checkbox"/> feeling inferior        | <input type="checkbox"/> feel like smashing things |
| <input type="checkbox"/> nightmares               | <input type="checkbox"/> can't make decisions    | <input type="checkbox"/> weight gain               |
| <input type="checkbox"/> poor appetite            | <input type="checkbox"/> overly ambitious        | <input type="checkbox"/> excessive overeating      |
| <input type="checkbox"/> excessive medication use | <input type="checkbox"/> loss of sexual interest |  |
| <input type="checkbox"/> feeling tense            | <input type="checkbox"/> can't make friends      |  |
| <input type="checkbox"/> excessive drug use       | <input type="checkbox"/> easily excited          |  |