UPSTATE MUSIC THERAPY CENTER LLC
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(585) 377-1000
upstatemusictherapycenter.com

COMMUNITY MUSIC SERVICES
Questionnaire

Name of Participant _____ D.O.B. _____

Parent/Relative Name(s) _____

Address _____ City _____

Zip _____ Phone _____

Email Address _____

School District/County_____

1. Does your child/relative have a formal diagnosis? (if yes, please specify) (if no, please list concerns)

2. Does your child/relative have any visual or hearing difficulties?

3. Does your child/relative exhibit any noticeable sensitivity to sound, touch or movement?

4. Does your child/relative have any physical limitations; behavior needs or medical concerns that the class leader should be aware of?

5. What family members lives in the home with the child/relative? (List all, ages and any special needs)

6. Does your child/relative attend pre-school, school-age or community program? (if yes, specify name and days/hours)

7. What therapies is your child/relative currently receiving?

8. What types of responses have you seen your child/relative have to music?

If your child/relative receives Music Therapy services, please provide a copy of the child's/relative's IEP or Plan including goals and objectives, as this will be helpful for the class leader.

Form completed by:

_____ _____

Guardian/Parent Name (Print) Relationship to child/relative

REFER TO OUR WEBSITE FOR AVAILABLE CLASS OPTIONS
upstatemusictherapycenter.com