Application for Music Therapy services
Music Therapy Center
Eastern Michigan University

Client Name ____ Date of Birth ____________

Caretaker Name(s) ____

Address ____

Phone ___________________________ Email ___________________________________

Best days and times for sessions: ____

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Please fill out any of the following that apply to the client:

Visual problems ___________________ Hearing problems _________________________

Ambulation ______________________ Reading skill _____________________________

Medications____

Communication abilities ____

Preferred types of music ____

Reason for Seeking Music Therapy ____

Potential Goal areas: (please describe briefly)

Motor Development ____

Cognitive development ____

Language/communication development ____

Emotional development ____

Personal leisure skill development ____