Individualized Music Therapy Assessment Profile (IMTAP)

Intake Form

Intake Date: _____
Year Month Day

Client's Name: _____ Sex: M F Birth Date: _____
Year Month Day

Therapist's Name: _____ Chronological Age: _____
Years Months Days

Referring Individual: _____

Interviewee's Name: _____ Relationship to Client: _____

Please note: Questions on this form are of a personal and confidential nature. Therapist should exercise appropriate judgment when completing intake. Completion of this form is not a requirement for music therapy services.

General information		
Does the child have a current diagnosis? *Dx:* *Who gave this diagnosis?*	Yes	No
Is the child on any medications? *Meds:*	Yes	No
Does the child have any allergies or sensitivities?	Yes	No
Are there any precautions I should take in working with the child? (i.e. seizures, biting, self-injurious behavior, etc.)	Yes	No
Does the child participate in any other therapies? *Therapies:*	Yes	No
Has the child had any previous musical experience or exposure?	Yes	No
Do you believe the child has any particular musical aptitude?	Yes	No
Are there any musicians in the child's immediate family? *Who?*	Yes	No
Have you noticed that the child has any musical preferences?	Yes	No
What benefit do you anticipate from music therapy?		

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Note to therapist: Any indications in the left-hand/shaded column indicate that this area of functioning should be assessed.

Gross motor		
Have you noticed that the child has any gross motor difficulties?	Yes	No
Is the child fully ambulatory?	No	Yes
Does the child require any physical assistance?	Yes	No
Does the child have full use of all of his/her limbs?	No	Yes

Fine motor		
Have you noticed that the child has any fine motor difficulties?	Yes	No
Is the child able to perform fine motor tasks with both hands? (i.e. eat with utensils, button a button, hold a pencil)	No	Yes
Does the child frequently drop items or have difficulty holding objects?	Yes	No

Oral		
Does the child have any feeding issues?	Yes	No
Does the child have any respiratory issues?	Yes	No

Sensory		
Have you noticed that the child has any sensory issues?	Yes	No
Does the child resist physical support?	Yes	No
Does the child engage in any repetitive behaviors?	Yes	No
Does the child have any deficits in hearing, vision, or other senses?	Yes	No
Does the child have any sensitivities to/or extreme preferences for particular sounds?	Yes	No
Is the child over-stimulated by sounds, lights, or crowds?	Yes	No

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Receptive communication/auditory perception		
Has the child been diagnosed with any hearing difficulties? *If so, has an audiogram been done and what were results:*	Yes	No
Does the child have difficulty hearing sounds or understanding speech?	Yes	No
Does the child have a history of ear infections?	Yes	No
Does the child understand or react to what is being said to him/her?	No	Yes

Expressive communication		
Have you noticed that the child has any speech or language difficulties?	Yes	No
Does the child communicate verbally? *If not, please indicate mode of communication:*	No	Yes
Do others easily understand the child?	No	Yes
Does the child have any idiosyncratic speech?	Yes	No

Cognitive		
Have you noticed that the child has any cognitive deficits or difficulties?	Yes	No
Does the child have an IEP (Individualized Education Plan)?	Yes	No
Is the child in with same-age peers in their educational setting?	No	Yes

Emotional		
Have you noticed that the child has any emotional difficulties?	Yes	No
Does the child show emotions appropriately?	No	Yes
Does the child tantrum or get angry easily?	Yes	No
Has the child suffered any emotional trauma or recent change in life circumstances?	Yes	No

Client Name: _____ **Intake Date:** _____

Social		
Have you noticed that the child has any social difficulties?	Yes	No
Does the child have any difficulty relating to family members?	Yes	No
Does the child have a social group of like-aged peers?	No	Yes
Does the child participate in conversation or play with others?	No	Yes
Does the child have any particular difficulties in school or other social situations?	Yes	No

Is there anything we have not covered that you feel is important?

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Therapist notes:

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Client Name: _____ **Intake Date:** _____

Intake Summary:

Please check applicable categories based on above information:

- ☐ Gross Motor
- ☐ Fine Motor
- ☐ Oral Motor
- ☐ Sensory
- ☐ Receptive communication/auditory perception
- ☐ Expressive communication
- ☐ Cognitive
- ☐ Emotional
- ☐ Social
- ☒ Musicality

_____ _____

Signature Date