LIVE THERAPEUTIC MUSIC DATA COLLECTION FORM

Session Date:_____ ***Time:***_____ ***Patient ID:*** _____

Age (*check ONE*): □ under 18 □ over 18 ***Gender*** (*check ONE*): □ Female □ Male

Patient Location (*check ONE*): □ Hospital □ Home □ Caregiver/Relative's Home
□ Non-hospital Medical Facility (specify):_____

Medical Diagnosis (*check ALL that apply*):

□ Cancer □ Skeletal/Orthopedic □ Obstetrics
□ Pulmonary □ Dementia/Alzheimer's □ Psychiatric/Mental health
□ Cardiac □ Failure to thrive □ Other (specify): _____
□ Neurological □ Surgical

Before Music Session – Presenting Conditions:

	Check ONE column in EACH row:		
Observed General Conditions	**Yes**	**No**	**Can't tell**
Awake			
Confused/Disoriented			
Smiling			
Crying			
Verbally coherent			
Non-responsive			
Restless			
Agitated			
Moaning			
Furrowed brow			
Clenched hands			
Curled up/Tense position			
Other (specify): _____			

Observed Breathing Conditions *Circle ONE number for each condition:*					
Erratic	1	2	3	4	Steady
Shallow	1	2	3	4	Deep
Relaxed	1	2	3	4	Labored
Cheyne-Stokes present	1	2	3	4	Cheyne-Stokes absent

	Complete as many of these as available:
Measured Conditions	**Measurement**
Blood pressure	_____ / _____
Heart rate	_____ beats/min
Oxygen saturation	_____ %
Respiratory rate	_____ breaths/min
Other (specify): _____	

Additional Concerns affecting Music Session *(check ALL that apply)**:***

□ Hearing impaired □ Intubated □ In medical isolation □ Language barrier
□ In hospice care □ Interruptions during session □ Other (specify): _____

During Music Session – Types of Music Used *(check ALL that apply)**:***

□ Familiar music	□ Calming/Sedating (<50 beats/min)
□ Unfamiliar music	□ 50 to 70 beats/min
□ Rhythmic music	□ Stimulating/Upbeat (>70 beats/min)
□ Arrhythmic music	□ Other (specify): _____
□ Improvisational music	

Length of session: _____minutes ***Instrument(s)/Voice used:*** _____

After Music Session – What Changed?:

	Check ONE column in EACH row:		
Observed General Conditions	**Yes**	**No**	**Can't tell**
Awake			
Confused/Disoriented			
Smiling			
Crying			
Verbally coherent			
Non-responsive			
Restless			
Agitated			
Moaning			
Furrowed brow			
Clenched hands			
Curled up/Tense position			
Other (specify): _____			

Observed Breathing Conditions *Circle ONE number for each condition:*					
Erratic	1	2	3	4	Steady
Shallow	1	2	3	4	Deep
Relaxed	1	2	3	4	Labored
Cheyne-Stokes present	1	2	3	4	Cheyne-Stokes absent

	Complete as many of these as available:
Measured Conditions	**Measurement**
Blood pressure	_____/_____
Heart rate	_____ beats/min
Oxygen saturation	_____%
Respiratory rate	_____ breaths/min
Other (specify): _____	

Narrative Note ***(e.g., patient, staff, and/or caregiver comments; why you chose the music you did; patient response and CMP observations not mentioned above; comments about patient's pain before and after, if known/applicable, etc.):***

Facility location (City, State): _____

Print your name and title: _____

Signature: _____ **Date:**_____

Mail completed form to: MHTP™ Central Office, P.O. Box 127, Hillsdale NY 12529