



**RAAGA MUSIC THERAPY LLC**

**6315 Adirondack Court, Gainesville VA – 20155 (USA)**

**[www.raagamusictherapy.org](http://www.raagamusictherapy.org)**

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# Raga Music Therapy (RMT) Patient Assessment

## Initial assessment or After 3 weeks of RMT

**A. 1. Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Place of birth:** \_\_\_\_\_ **Gender:** M/F; **Date:** \_\_\_\_\_

**Doctor's name/or treatment facility's Name?** \_\_\_\_\_

**Contact Details: Phone** \_\_\_\_\_ **Email** \_\_\_\_\_

**2. What is your Medical Diagnosis? (Circle, all applicable):**

- a. Hypertension (High blood pressure) b. Diabetes Mellitus c. Thyroid disorder (Hyper or Hypothyroidism) d. Cancer (any type) e. coronary artery disease f. stroke and/or dementia  
g. Other \_\_\_\_\_

**3. How long have you been diagnosed with the illness noted above?**

- a. less than one year (1) b. 1-3 years (2) c. 3-5 years (3) d. more than 5 yrs. (4)

**4. Do you take medication(s) for the conditions noted above, If yes, how many?**

0 \_\_\_ 1 \_\_\_ 2 \_\_\_ 3 \_\_\_ > 4 or more

**5. In general, how is your health?**

Excellent (0) /Good (1)/Fair (2)/Not Good (3)

**B. Please answer the following questions on how you feel. (Circle, most appropriate?)**

0 (Never)/ 1 (Sometimes) /2 (Often)/3 (Very Often)

- a. Feel upset, if something happens unexpectedly or things don't go as planned?

0 \_\_\_ 1 \_\_\_ 2 \_\_\_ 3 \_\_\_

- b. Feel, are you unable to control important things in your life?

0 \_\_\_ 1 \_\_\_ 2 \_\_\_ 3 \_\_\_

- c. Feel nervous, anxious or stressed? 0 \_\_\_ 1 \_\_\_ 2 \_\_\_ 3 \_\_\_

- d. Not being able to stop or control worrying? 0 \_\_\_ 1 \_\_\_ 2 \_\_\_ 3 \_\_\_

- e. Feel little interest or pleasure in doing things? 0 \_\_\_ 1 \_\_\_ 2 \_\_\_ 3 \_\_\_

- f. Feel tired or have little energy? 0 \_\_\_ 1 \_\_\_ 2 \_\_\_ 3 \_\_\_

- g. Have trouble falling or staying asleep or



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waking up too early? 0\_\_\_1\_\_\_2\_\_\_3\_\_\_

h. To what extent do you consider your sleep problem

interferes with your daily chores or mood. 0\_\_\_1\_\_\_2\_\_\_3\_\_\_

i. Do you feel pain, anywhere in your body:

No pain (0); Mild pain (1); Moderate pain (2); Severe pain (3)

**C.** Have you tried Natural therapy (Ayurvedic, naturopathy, meditation or Yoga) for your condition? If yes, please explain which therapy and for how long? \_\_\_\_\_

**D.** Please answer the following questions about RMT, after its use:

a. Did you listen to music as recommended: Yes/No. If no, please give reason \_\_\_\_\_

b. Did you listen to music alone or with someone?

c. Do you feel any change in your mood, stress or energy level? If yes, please explain: \_\_\_\_\_

d. Is there any change in your blood pressure or medicines since the start of using RMT? If yes, please explain: \_\_\_\_\_

e. Have you noticed any change in your sleep pattern, since the start of RMT? If yes, please explain: \_\_\_\_\_

f. Would you like to continue receiving RMT after 3 weeks course: Yes/No