

**RCH Gender Care Center**

501 N. Graham St, Suite #375

Portland, OR 97227

503.413.1600

503.413.1915 (fax)

[crobert@lhs.org](mailto:crobert@lhs.org) (RN Email)

**New Patient Intake Form**

Date:  Click here to enter text.

Legal Name:  Click here to enter text.

Preferred Name: Click here to enter text.

Pronouns: Click here to enter text.

Do you have a word or words you use to describe your gender identity? Maybe you identify as female or male or trans male or non-binary, for example? If so, what word(s) do you use?

Click here to enter text.

Is your gender identity something you feel comfortable talking about with your family?

Click here to enter text.

Please tell us a little bit about your gender journey. When did you start thinking about your gender? When did you feel comfortable starting to talk about it? Who did you tell first?

 Click here to enter text.

How has it been going?

 Click here to enter text.

Who are all the people you live with? How is your relationship with them? Do you feel supported in your gender identity? Who supports you in your family and community?

Click here to enter text.

Is there anyone that does not support your gender identity in your family? In your community (friends, school, church, et.)?

 Click here to enter text.

Are you attending school?

Name of School : Click here to enter text.

Grade: Click here to enter text.

What name and pronouns do you use at school?

Click here to enter text.

Is that the name and pronouns you want to use at school?

Click here to enter text.

Are there things you like about school? If so, what?

Click here to enter text.

Are there things you don’t like about school? If so, what?

Click here to enter text.

Are there any adults at school you feel comfortable talking to? If so, who?

Click here to enter text.

Do you have a place that you can comfortably use the bathroom at school?

Click here to enter text.

Are there any concerns you have about school?

   Click here to enter text.

Are you connected to other trans or gender diverse youth? If so, how has that been? If not, is that something you are interested in?

 Click here to enter text.

Medical History:

Do you have any ongoing medical conditions we should know about?

  Click here to enter text.

Do you take any medications on a regular basis? If so, what?

  Click here to enter text.

Mental Health History:

Are you working with a mental health provider?

Click here to enter text.

If so, what is their name?

Click here to enter text.

When did you start seeing them, and how often do you see them?

Click here to enter text.

Do they feel like they are a good fit for you?

Click here to enter text.

Do you feel comfortable talking to them about your gender identity?

 Click here to enter text.

Have you talked with your therapist about coming to T-Clinic?

Click here to enter text.

Do they work with your family at all too?

Click here to enter text.

Do they have experience with gender identity?

  Click here to enter text.

Do you have any mental health diagnoses, such as anxiety, depression? If so, what have you been diagnosed with and how does it affect you?

 Click here to enter text.

Are you taking medication for your mental health? If so, what?

Click here to enter text.

Have you been hospitalized for mental health concerns? Can you tell us a little more about when that was and what was going on?

 Click here to enter text.

Is there anything else about you that you would like us to know about?

Click here to enter text.

What are your hopes in coming to T Clinic? Do you have any concerns you would like to let us know?

 Click here to enter text.

Please return completed form to:

Behavioral Health Clinician at beginning on intake appt or before intake appt at:

Clancy Roberts, LCSW at

501 N Graham St Suite 375

Portland, OR 97227 (please note, snail mail takes up to 2-3 weeks to reach its final destination)

(503) 413-1600 (ph.) 503-413-1915 (fax)

Email: crobert@lhs.org