**RCH Gender Care Center**

501 N. Graham St, Suite #375

Portland, OR 97227

503.413.1600

503.413.1915 (fax)

crobert@lhs.org (RN Email)

**New Patient Intake Form**

Date:  Click here to enter text.

Your child’s Legal Name:  Click here to enter text.

Your child’s Preferred Name: Click here to enter text.

Your child’s pronouns: Click here to enter text.

Date of Birth:  Click here to enter text.

Legal name change? Click here to enter text. (if yes, please bring paperwork)

Your name: Click here to enter text.

Best phone number to contact you: Click here to enter text.

Best email to contact you: Click here to enter text.

Tell us a little bit about your child’s gender journey. When did they start talking about it? To you? To others? Are there things you noticed in early childhood? When/if puberty hit?

 Click here to enter text.

Has your child socially transitioned?  (Appears as and presents self (hair, clothes, name, pronouns, etc) as identified gender. All the time? At home? School? Other conditions?)

 Click here to enter text.

Please describe your child’s current living situation (custody if applicable, time spent at different homes etc.)

 Click here to enter text.

Please give us an idea of family members’ support of patient’s gender identity.

 Click here to enter text.

How about your community support? Their friends?

Click here to enter text.

Is there anyone in your child’s life that does not support this part of who they are? What has the impact been on you, your child?

 Click here to enter text.

Is your child attending school?  Click here to enter text.

Does your child use preferred name, pronouns at school?

 Click here to enter text.

What are your child’s supports and struggles at school around gender identity?

Click here to enter text.

Strengths at school are:

Click here to enter text.

Struggles with school are:

Click here to enter text.

Is there a point of contact you have with school to navigate support, gender or otherwise:

Click here to enter text.

If so, who? Click here to enter text.

 What have they done that has been helpful? Click here to enter text.

Is there anything else that school could do to be a more supportive space? Click here to enter text.

Please list any sources of support around gender expansiveness for:

Your child:  Click here to enter text.

You, as parents/guardians:  Click here to enter text.

Does your child have contact with other trans or gender diverse youth?  If so, can you tell us about that experience? Do you have any contact with other parents of trans or gender expansive youth? If so, can you tell us about that experience?

 Click here to enter text.

Medical History:

Does your child have any ongoing medical conditions we should know about?

  Click here to enter text.

Please list current medications taken on a regular basis:

  Click here to enter text.

Mental Health History:

Is your child seeing a mental health provider currently?  Click here to enter text.

Name of Provider:  Click here to enter text.

Phone Number: Click here to enter text.

E-mail: Click here to enter text.

Length of time with this provider: Click here to enter text.

To your knowledge, is your provider knowledgeable in working with gender diverse youth and their family system?  Click here to enter text.

Are you involved in your child’s care with their therapist?

 Click here to enter text.

Have you talked with the therapist about coming to T Clinic for medical intervention?

Click here to enter text.

Does your child have any mental health diagnoses, such as anxiety, depression? If so, what has your child been diagnosed with and how does that affect them? Your family?

 Click here to enter text.

Are they taking medication for your mental health? If so, what, for how long, and who prescribes it?

Click here to enter text.

Has your child 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 your child or you that you would like us to know about?

 Click here to enter text.

What are your expectations of coming to T Clinic?

Click here to enter text.

Do you have any concerns you would like to let us know about?

 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