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 T-Clinic-YOUTH

 *Providing Excellence in Multi-Disciplinary Care to Transgender and Gender Expansive Youth*

Main Office /Mailing Address Cornell Location

501 N Graham St Suite 375 1960 NW 167th Place Suite 103

Portland, OR 97227 Beaverton, OR 37227

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

Email: crobert@lhs.org

**T Clinic New Patient Intake Information Form**

(may write answers on back of page)

Date:

Legal Name:

Preferred Name: Pronouns:

Date of Birth:

Legal name change? (if yes, please bring paperwork to first visit for check in)

Gender Identity:

Tell us a little bit about your gender journey. When did you know? When and how did you tell your parents? When did you tell others? How did that go?

Have you socially transitioned?  (Appear as and present self (hair, clothes, etc) as identified gender) All the time? At home only? Other conditions?

Please describe your current living situation (parental custody if applicable, time spent at different houses etc.)

Please give us an idea of family members’ acceptance of your gender identity.

How about your friends’ acceptance? Friends’ parents?

Are you attending school?

Name of School : Grade:

Is the school aware of identified gender?

Has the school accepted identified gender?

Bathroom/locker room issues?

Enrolled with preferred name?

Bullying experience?

Learning challenges?

Please list your sources of support:

Do you have contact with other trans or gender expansive youth?  If so, is it a positive experience?

Medical History:

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

Please list current medications taken on a regular basis

Mental Health History:

Do you have a mental health provider currently?

Name of Provider

Contact Info:

Phone Number:

Length of time with this provider

To your knowledge, is your provider comfortable working with gender expansive youth?

Are they in agreement with you coming to T Clinic for medical intervention?

Do you have any mental health diagnoses, such as anxiety, depression etc?

Please Explain:

Please list medications to treat these conditions if applicable.

Have you been hospitalized for mental health concerns, such as suicidal ideation or attempt?

Please provide date(s) and short summary of experience.

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

What are your expectations of coming to T Clinic?

Please return completed form to:

Check in Desk

 -or-

 if filling out remotely return to

Clancy Roberts, LCSW at

501 N Graham St Suite 375

Portland, OR 97227

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

Email: crobert@lhs.org

We are excited to learn about you!