

**INITIAL INTAKE QUESTIONNAIRE – TRANSGENDER HORMONE THERAPY**

Date of Birth:   
(MM/DD/YYYY)

Legal Name:

Sex Assigned At Birth:  Male  Female  
(listed on your birth certificate)

Preferred Name:

Sex Listed with Insurance:  Male  Female  
(if applicable)

Sexual Orientation (who you are attracted to – mark all that apply):

- Male
  Female
  Neither
  Both
  Not Sure

Gender Identity (your deep seated internal sense of your own gender):

- Male
  Female
  Neither
  Both
  Not Sure

What are you hoping Hormone Therapy will do for you?

Aside from hormones, are there other changes you are considering or thinking about making?

Who knows about your plans to start hormones? (mark all that apply)

- Family
  Friends
  Partner
  No one
  Other (please specify)

How are you thinking about coping with stressors from changes you will experience?

**If transitioning to female:** how do you handle depression when you get sad?

**If transitioning to male:** how do you handle anger when it happens?

Do you live alone?  Yes  No

If you live with others, does it feel like a safe place to transition?  N/A  Yes  No

If you work, are you out at work or considering talking to your employer?  N/A  Yes  No

If you go to school, are you out at school or considering talking to your school?  N/A  Yes  No

If you date or have a partner, have you thought about how you might talk to them about your gender identity?  N/A  Yes  No

Patient Signature:

Date:

Staff Signature:

Date:

Clinician Signature:

Date: