# Semicolon Counseling
# New Client Surgery Intake Form

This form helps us learn about your history. Please complete it to the best of your ability. Not every question may be relevant. If you feel uncomfortable answering a question, leave it blank.

Date:_______________

Chosen Name__________________________ Legal Name____________________

What pronouns do you use (examples include she, he, they, and ze)? __________

Date of Birth _____________________ Insurance Company:_________________

How do you identify (check all that apply):

☐ Male ☐ Female ☐ FTM ☐ MTF

☐ Transgender ☐ Genderqueer ☐ Gender non-conforming ☐ Transsexual

☐ Gender non-binary ☐ Two Spirit ☐ Intersex

☐ Transfeminine ☐ Transmasculine

What is your relationship status?

☐ Polyamorous ☐ Non-monogamous ☐ Monogamous ☐ Single, Dating ☐ Single, Not Dating

How is your partner/spouse affirming/not affirming of your gender journey?

_________________________________________________________________

Who is in your support system? Who do you talk to about your problems (e.g., feeling sad or angry)? Check all that apply.

☐ Significant other ☐ Friends ☐ Family of origin

☐ Therapist ☐ Support group/online support group

☐ Community organization/agency (such as LGBT Center)

Are you out as transgender or openly living as your self-identified gender at work/school?

☐ No one knows ☐ Some people know ☐ Everyone knows

If not, would you feel safe if you choose to come out? ☐ Yes ☐ No

Are the following people aware of and supportive of your transition/gender identity and expression?

Employer/school Aware ☐ Supportive ☐ Family of origin Aware ☐ Supportive ☐

Significant other Aware ☐ Supportive ☐ Friends Aware ☐ Supportive ☐

Do you feel you are unable to present your authentic gender in daily/personal situations? (i.e. work, home/parents, safety reasons):

___________________________________________________________________________________

Have you had any negative experiences related to your gender expression? (i.e. loss, violence, trauma)
If so, how did you deal with it?

_______________________________________________________________________________________

How do you currently present/express your gender? Are you living in alignment with your authentic gender? Are you exploring? If so, how long? If not, why do you feel you can't/aren't able to?

_______________________________________________________________________________________

What is your earliest memory of your gender being at odds with your assigned sex?

_______________________________________________________________________________________

Have you ever discussed medical transition (hormone therapy and/or surgery) with a healthcare provider?
☐ Yes ☐ No or N/A (Skip to next question)

If yes, when were you first diagnosed with gender dysphoria? ___________________
What clinic or provider diagnosed you? ______________________

Have you had the opportunity to work with a mental health professional regarding concerns related to gender identity? ☐No ☐Yes Name:________________________

What hormone treatments have you been on, when, and for how long? These can be those you were prescribed, shared with you by others, or bought without a prescription. Include any treatment you currently take.
☐ None (Skip to next question)

| What | Dose | When did you start? | How long have you taken it? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Have you had any problems, complications, or other difficulties with hormone treatment? ☐ Yes ☐ No

If yes, please list them:_________________________________
If you are not taking hormones, were you on hormone therapy in the past? ☐ Yes ☐ No
Are you interested in starting or re-starting hormone therapy? ☐ yes ☐ No
If yes, what are you hoping hormones will do for you? ____________________
If yes, what (if any) are your concerns about taking hormones?________________

Have you ever had a menstrual period? ☐ Unsure ☐ Yes ☐ No (Skip next question)
Do you ever feel any Dysphoria when you are on your period? ☐Unsure ☐ Yes ☐ No

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**Gender Identity Questions:**

1. Do you feel your inner gender identity is at odds with your assigned sex at birth (for at least six months)?
☐ Never ☐ Sometimes ☐ Always
2. Do you dislike your genitals and secondary sex characteristics (i.e., facial hair or breasts) of your assigned gender (for at least six months)?
☐ Never ☐ Sometimes ☐ Always
3. Would you be happier if you had the primary (i.e., penis/vagina) or secondary sex characteristics (i.e., facial hair, breasts, wider hips) of the opposite gender? For example, have you considered procedures (hormone therapy/surgical sexual reassignment) to physically alter your sexual characteristics (for at least six months)?
☐Never ☐Sometimes ☐ Always

4. Do you have the desire to be of the other gender or some alternative gender different from your assigned gender (for at least six months)?
☐Never ☐Sometimes ☐ Always
5. Do you wish that the people in your life would treat you the same way they treat males (if your assigned gender is female) or females (if your assigned gender is male)?
☐Never ☐Sometimes ☐ Always
6. Are you experiencing distress or impairment in social, occupational, or other important areas of functioning, given the disconnect you experience between your gender at birth and your expressed/preferred gender?
☐ Never ☐Sometimes ☐ Always

**Gender-Affirming Surgery:**

Have you had a surgical consultation for gender-related surgery? ☐ Yes ☐ No
If yes, what is the doctor's name? ____________________________
Is there a surgery date? ☐ Yes ☐ No If yes, when is the surgery? ___________________

Who is taking care of you after you have surgery? _____________________________________

Are you looking for a letter for revisions? ☐ Yes ☐ No

| Please mark if you have had the surgery or if you want it. | Have had | Want |
|---|---|---|
| **Masculinizing procedures**: | | |
| Chest reconstruction (top surgery) | | |
| Body contouring | | |
| Hysterectomy (removal of the uterus) | | |
| Oophorectomy (removal of ovaries) | | |
| Metoidioplasty or phalloplasty (surgery to form a neophallus or penis) | | |
| Other:_____________________________ | | |
| | | |
| **Feminizing procedures:** | | |
| Orchiectomy (removal of testes) | | |
| Vaginoplasty | | |
| Breast augmentation | | |
| Body contouring | | |
| Silicone injection | | |
| Facial feminization | | |
| Tracheal shave | | |
| Other:______________ | | |

**Do you use any prosthetics or compression techniques to express your gender?**
(binding, packing, breast forms, padding, tuck, etc.) ☐ Yes ☐ No (Skip to next question)

If yes, how many hours per day? ___________

Do you have any complications? (chronic pain, urinary tract infections (UTIs), fungal infections, rashes, acne, broken bones, etc.) _______________________________

Do you have any medical concerns that might affect your getting surgery?

________________________________________________________________________________

________________________________________________________________________________

What are your expectations for this surgery?

_______________________________________________________________________________

_______________________________________________________________________________

Have you updated your name and/or gender marker on all identity documents you want to change? ☐ No ☐ Yes

Do you want assistance updating your identity documents if you still need to? ☐ Yes ☐ No

If yes, which documents would you like to update?

☐ Social Security Card
☐ Driver's License or State-Issued ID
☐ Passport
☐ Green Card
☐ Birth Certificate (if checked, please tell us which state you were born in) ___________________

What would you like to change?

☐ Name only
☐ Gender Marker only (will need doctor's letter to change some identity documents in certain states)
☐ Name and Gender Marker (will need a doctor's letter to change some identity documents in certain states)

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**Employment, & Housing**

**Are you working or in school?** (Check all that apply.)

☐ Yes, my current job is:__________
☐ No, I'm unemployed
☐ No, I'm retired.
☐ No, I'm on disability for: _____________
☐ Yes, I'm in school for: _______________

**What is your current living situation?**

☐ House or Apartment (Stable/Permanent)
☐ In a Residential Treatment Program
☐ On the Street
☐ With friends/family (Temporary)
☐ In a Vehicle
☐ In a Shelter
☐ In a Single Room Occupancy (SRO) Hotel since _________

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## Mental Health History

What mental health conditions have you been diagnosed with? ☐ None (Skip this section)

☐ Depression
☐ Anxiety
☐ PTSD
☐ Bipolar I
☐ Bipolar II
☐ Obsessive Compulsive Disorder
☐ Other mental health conditions not listed:
☐ Gender Dysphoria
☐ Schizoaffective Disorder
☐ ADD/ADHD
☐ Autism Spectrum Disorder
☐ Eating Disorder
☐ Substance Use Disorder (sober or currently using)
☐ Alcoholism (sober or currently using)

Past Psychiatric History and Treatment: Inpatient, Outpatient, Number of Occurrences, Suicide Attempts, History of Suicidal / Homicidal Ideation, Past Diagnoses, past behaviors

_______________________________________________________________________________

_______________________________________________________________________________

## Mental Health Screening

Current Symptoms Checklist

- ☐ Decreased interest in activities
- ☐ Hallucinations
- ☐ Panic attacks
- ☐ Decreased libido
- ☐ Irritability or Suspiciousness
- ☐ Sleep pattern disturbance
- ☐ Worthlessness or excessive guilt
- ☐ Depressed or sad mood
- ☐ Low self-esteem
- ☐ Excessive energy
- ☐ Low motivation
- ☐ Excessive worry
- ☐ Poor concentration
- ☐ Weight or appetite change
- ☐ Fatigue or loss of energy

**We ask all clients about safety, mental health, and substance use because this can significantly affect your overall health.**

**Over the past two weeks, how often have you been bothered by:**

*Feeling nervous, anxious, or on edge?*

☐ Nearly every day ☐ More than half the days ☐ Several Days ☐ Not at all

*Not being able to stop controlling worrying?*

☐ Nearly every day ☐ More than half the days ☐ Several Days ☐ Not at all

**Over the past two weeks, how often have you been bothered by:**

*Having little interest or pleasure in doing things you usually enjoy?*

☐ Nearly every day ☐ More than half the days ☐ Several Days ☐ Not at all

*Feeling down, depressed, or hopeless?*

☐ Nearly every day ☐ More than half the days ☐ Several Days ☐ Not at all

*Do you often have trouble sleeping?*

☐ Nearly every day ☐ More than half the days ☐ Several Days ☐ Not at all

**The following are symptoms that people sometimes have after experiencing, witnessing, or being confronted with a traumatic event. Please answer according to how much the symptoms have bothered you since the trauma.**

*Recurrent thoughts or memories of the event.*

☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Not at all

*Feeling as though the event is happening again.*

☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Not at all

*Recurrent nightmares about the event.*

☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Not at all

*Sudden emotional or physical reactions when reminded of the event.*

☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Not at all

*Avoiding activities that remind you of the event.*

☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Not at all

*Avoiding thoughts or feelings associated with the event.*

☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Not at all

*Feeling jumpy or easily startled.*

☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Not at all

*Feeling on guard.*

☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Not at all

Have you experienced trauma that you believe affects your mental health? ☐ Yes ☐ No Trauma History (optional)

______________________________________________________________________________

______________________________________________________________________________

**Suicide Risk Assessment**

Have you ever had feelings or thoughts that you didn't want to live? ☐ Yes ☐ No (Skip this section)

Do you currently feel that you don't want to live? ☐ Yes ☐ No

If Yes: On a scale of 1 to 10 (10 being strongest), how strong is your desire to kill yourself currently?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Have you ever attempted suicide? ☐ Yes ☐ No

Do you have the means or a plan to kill yourself? ☐ Yes ☐ No

**Substance Use Screening**

**Do you currently use or have you ever used tobacco products?** ☐ Yes ☐ No (Skip this section)

**If yes, in terms of tobacco use, are you a:**

☐ Current cigarette smoker

When did you first start smoking? ____________

How many cigarettes do you smoke per day? ____________

Are you interested in quitting? ☐ No ☐ Thinking about quitting ☐ Ready to quit

☐ Former cigarette smoker

When did you quit smoking? _________On average, how many cigarettes did you smoke per day?________

How many years did you smoke?___________

☐ Other tobacco users (Circle: cigars, hookah, chew, vape). How often and for how many years?_________________

**How many times in the past year have you had four or more alcoholic drinks in 1 day?______** ☐ None (Skip this section)

Are you interested in quitting? ☐ No ☐ Thinking about Quitting ☐ Ready to Quit

**Do you currently use or have you ever used recreational or prescription drugs for non-medical reasons?** ☐ Yes ☐ No (Skip this section)

If yes, how often have you used a recreational or prescription drug in the past year for non-medical reasons?_________

If you use opioids, do you have access to Narcan (Naloxone)? ☐ Yes ☐ No

Are you interested in quitting? ☐ No ☐Thinking about Quitting ☐Ready to Quit ☐Not Applicable

Is there anything else I should know to help me write the letter?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________