

**GENDER AFFIRMING CARE CLINIC
(GACC) INTAKE QUESTIONNAIRE**

Client: _____

DOB (yyyy/mmm/dd): _____

HRN / MHSC: _____

PHIN #: _____

Addressograph/Place Label Here

Date: _____ **yyyy/mmm/dd**

Chosen/Preferred Name: _____

Legal Name: _____

Preferred Pronouns: _____

Age: _____

Do you have a family doctor? Yes No

Would you like to be added to GACC distribution list for emails to receive information on upcoming events and programs, etc.? Yes No

This questionnaire helps the GACC team better understand your goals and history prior to your initial visit. We will review this together. Please do not worry if you cannot answer all the questions or don't feel comfortable answering any or all of these questions. All of your answers are kept completely confidential.

Past Medical History:

Please list any/all diagnoses you have been given by a medical provider. Any history of migraine headache?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

(please continue on backside of page as needed)

Current medications/over the counter supplements:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

(please continue on backside of page as needed)

Do you:

1. Smoke/vape cigarettes: Yes No If yes, how many per day? _____
For how long have you been a smoker? _____
2. Drink alcohol? Yes No If yes, how many drinks per day or week? _____
3. Use other recreational drugs? Yes No

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Tell us a bit about yourself. Where do you live? Who lives there with you? Are you working/in school, etc.?

When did you first start exploring gender/gender identity/expression? What sort of thoughts or feelings have you been having surrounding gender?

How would you describe your current gender identity?

What are aspects of your outward appearance/physical attributes that cause you dysphoria? What are some goals or things you would like to change/need help with in terms of gender?

Can you tell us how gender dysphoria (if present) impacts your day to day functioning?

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What aspects of gender affirming care (hormone replacement, social transition, legal name change, etc., gender affirming surgeries) are you interested in or thinking about?

What supports are you currently using?

- Mental Health Support
- EIA (Income Assistance)
- Disability Assistance
- Social Work
- Food Bank
- Housing
- Other

Are there any supports you would like to be connected to?

Any additional comments/questions?

Client's Signature

Date **yyyy/mmm/dd**

Nurse Signature

Date **yyyy/mmm/dd**