queer
therapeutic services

Clinical Intake

Therapist: _____ **Date:** ____/____/_____ **Time:** _____

Location: ☐ 2027 Broadway Boulder ☐ 827 Grant Street Denver ☐ 709 3rd Ave Longmont

Preferred Name: _____ **Legal Name:** _____

Phone number(s): _____ **Ok to leave a message?** yes no

Email: _____ **Ok to use?** yes no

Address: _____

Guardian if applicable (name/relation): _____ (p): _____

Emergency Contact (name/relation): _____ (p): _____

How did you hear about us? _____

Date of Birth: ____/____/_____ **Age:** _____ **Primary Language:** _____

Race/Ethnicity: _____ **Spirituality:** _____

Sex: transsexual *or* cissexual / female male intersex _____

Gender: transgender *or* cisgender / woman man agender non-binary _____

Pronouns: she/her/her he/his/him xe/xyr/xem they/their/them _____

Sexual Orientation: lesbian gay queer pansexual asexual straight _____

Relationship Orientation: polyamorous monogamous _____ **No. of Partners:** ____

Relationship Status: single partnered engaged married divorced widowed _____

Living: alone partner(s)___ child(ren)___ co-parent(s)___ family___ roommate(s)___ animal(s)___

Name/Relation/Age: _____

_____

Living situation: outside car apartment house shelter residential varies _____

Education: NA full-time part-time _____ School: _____ Degree: _____

Employment: full-time part-time disability retired looking unemployed_____

Place of Employment: _____ **Job Title:** _____

Military Service: active duty reserves veteran enlisted officer discharged retired _____

Identified Disabilities: _____

Major life events (moves, deaths, traumas): _____

_____

Legal history (criminal charges, probation)_____

_____

Medical history (diagnosis, medications, surgeries, allergies): _____

_____

Psychiatric history (diagnosis, medications, treatment team, hospitalizations): _____

_____

_____

Suicide/Homicide (ideation, intent, plan, attempts, hospitalizations): _____

_____

Substance Use (name/amount/frequency/duration, rehab, sobriety): _____

_____

Concerns about basic needs (housing, food, safety)? _____

_____

Physical health concerns (weight, diet, fitness)**:** _____

_____

Emotional health concerns (anxiety, depression, mania, trauma response)**:** _____

_____

Psychiatric health concerns (hallucinations, phobias, obsessions)**:** _____

_____

Spiritual health concerns (community, questioning)**:** _____

_____

Other concerns:_____

Symptoms:_____

_____

Resources:_____

_____

Strengths: _____ **Goals:** _____

_____ _____

Challenges: _____ _____

_____ _____