



P.O. Box 25172 Overland Park, Kansas 66209 913-626-1018

LGBTQI Intake Form

Legal Name _____

Name You Prefer to be addressed by _____

Pronoun You Prefer _____

Home Address _____ City _____ State _____

Zip Code _____ Hm phone _____ Cell Phone _____

Employer _____ Work Phone _____

Date of Birth _____

DCN# or insurance provider _____

Presenting Problem _____

When did you first begin to recognize that there was an issue? _____

What have you done to address the issue? _____

What are your current coping skills that you use? _____

Do you believe that they are effective? _____

Education History

What School do (did) you attend? _____

What was the highest grade level you earned or are earning? _____

Tell me about your family

Mother _____

Father _____

Siblings _____

Extended Family _____

Spouse or significant other _____

Children _____

Medical History

Primary Doctor _____

Address _____ Phone # _____

Last medical exam? _____

Have you experienced any of the following medical problems?

___ Head injury ___ Surgery ___ Seizures/convulsions ___ Asthma

___ High fever ___ Hearing problems ___ Vision problems ___ Allergies

Please list any current medical problems or physical handicaps. _____

Medication History

Current Med.	Dosage	Frequency	Prescribing Dr.	Reason	Compliance

Add any additional information regarding medications

here: _____

Has you ever made statements of wanting to seriously yourself or someone else?

Yes _____ No _____

If yes, please explain _____
