FAMILY TREE CLINIC

Place label here

Hormone Care Intake Form

Patient Legal Name: _____

Patient Chosen Name: _____

Date of birth: _____

At Family Tree Clinic, we focus our care around your individual goals. **Family Tree Clinic uses an informed consent model and your answers on this form will not determine whether or not you will be prescribed hormones.** Informed consent means you and your provider discuss the potential benefits, side effects, and risks of hormones and make a plan together without needing a letter from a therapist.

The following questions help your provider understand how to support your hormone care goals and guide your appointment. Feel free to skip questions that you don't understand or don't want to answer.

1. What changes are you hoping to see from hormone therapy? *You can mark by any of the listed words below and/or describe in your own words:*

Voice	Menstruation	Head Hair	Body Hair	Facial Hair
Skin	Muscles	Fat distribution	Face	Upper Body
Lower Body	Odor	Genitals	Fertility	Sex drive

2. Are there any specific changes you have questions or concerns about?

3. Are there any specific side effects you have questions or concerns about?

4. Is there anyone else that you see to support your health? ⬜ **Yes** ⬜ **No**
   If yes, please check all that apply:
   - ⬜ Primary Care Provider
     Clinic name: _____
   - ⬜ Therapist/psychiatrist
     Clinic name: _____
   - ⬜ Social worker/case manager
   - ⬜ Other healthcare provider
     Clinic name: _____

5. Have you worked with a mental health professional regarding gender identity? (Family Tree Clinic ***does not*** require a letter from a mental health provider or for a patient to be seeing a mental health provider to receive hormone therapy). ⬜ **Yes** ⬜ **No**

6. Are you currently taking any gender affirming hormone medications? ⬜ **Yes** ⬜ **No**
(This could be prescribed medications or medications you bought online or shared with friends.)
    a. If yes, what are you currently taking and for how long have you been taking them?

    b. Have you tried any other methods in the past? ⬜ **Yes** ⬜ **No**
    If yes, please check all that apply:

⬜ Injectables
⬜ Patches
⬜ Pills
⬜ Gel/creams
⬜ Implants

The next two questions ask about gender affirming surgeries, procedures, and treatments. Please know there are no requirements or expectations for pursuing any of these procedures. We ask these questions to allow your provider the opportunity to support your goals.

7. Have you had any gender affirming procedures/treatments? ⬜**Yes** ⬜**No** (skip to question 8)
If yes, which have you had:

8. Are you currently considering or interested in any gender affirming procedures/treatments besides hormone therapy? ⬜**Yes** ⬜**No** (skip to question 9)
If yes, which procedures/treatments:

⬜ Body contouring
⬜ Breast augmentation
⬜ Chest reconstruction (top surgery)
⬜ Facial feminization surgery
⬜ Facial masculinization surgery
⬜ Hysterectomy or oophorectomy (removal of the uterus/ovaries)
⬜ Laser hair removal or electrolysis
⬜ Metoidioplasty or phalloplasty (creation of a phallus)
⬜ Orchiectomy (removal of the testicles)
⬜ Silicone injection
⬜ Tracheal shave
⬜ Vaginoplasty or vulvoplasty (creation of a vagina/vulva)
⬜ Vocal therapy/coaching
⬜ Vocal surgery
⬜ Other: _____

9. Would you like to discuss fertility preservation with your provider (egg freezing, sperm freezing)?
⬜ **Yes** ⬜ **No** ⬜ **Not sure**

10. Have you legally changed your name and/or gender marker or are interested in doing so?
⬜ Yes, I have legally changed my name and/or gender marker
⬜ No, and I am not interested
⬜ No, but I want more information

11. Is there anything else you want your provider to know about your goals related to your healthcare and hormone therapy? Do you have any other questions or concerns?