GENDER CENTRE COUNSELLING INTAKE FORM

Intake Date ______________

Surname________________________ First Name _____________________________

Address____

Suburb ______________________________ State ___________ Postcode __________

Phone _______________________________

Email ____

Gender/pronouns (state the gender that best describes you) _______________

Date of birth___________________

Have you used this service before: Yes No If Yes, When _______________

What concerns are you hoping to work on in counselling? (Tick all that apply)

- Social transition
- Medical transition
- Gender identity
- Domestic violence
- Past trauma
- Family issues
- Mental illness
- Suicide ideation
- Parenting
- Alcohol/Drugs
- Other (please describe)

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