

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

Mental illness

Medical transition

Suicide ideation

Gender identity

Parenting

Domestic violence

Alcohol/Drugs

Past trauma

Other (please describe)

Family issues
