Pediatric and Adolescent Gender

Health Clinic Patient History Intake Form

Welcome to the Children's Gender Health Clinic and services. We look forward to helping your child and family. Please fill out this form and send it to the clinic. You **must return the form before we can make a clinic appointment** for your child. The directions where to send the form are at the end of the form.

During your clinic visit, the patient, your child, will be seen by a Pediatric Endocrinologist or Pediatric Nurse Practitioner. You will also see our Pediatric Health Psychologist. These providers have special education in gender health care.

Today's Date: _________

Patient's Full Legal Name: ________________________________

Preferred Name: ____ Birthdate: _____________

Preferred Pronoun (i.e. he, she, they): ____

Patient's home address: ____

Patient's phone number: (_____) ______________________

Name of patient's primary health care provider: ______________________________________

Phone number of patient's primary health care provider: (_____) ________________________

Tell us what matters most to you.

What are the patient goals?

____

How old was the patient when they first showed gender non-conformity? _____________________

Does the patient see a mental health therapist or psychiatrist now? ☐ Yes ☐ No

If the patient does see a therapist, do they help with the patient's gender questions or concerns?
☐ Yes ☐ No If yes, please give the therapist's contact information:

Therapist or Psychiatrist's Name: _________________ Phone: (_____) ______________

Office Address: _____________________________________ Email Address: ______________

Patient Medical History

Allergies: On the line below, list any medicines, foods, or other things like dusts, pets, or natural plants that the patient is allergic to. List what happens if the patient has those things around them or in their body.

____

Medicines: List the medicines that this patient takes for any reason

Medicine Name	How much do they take?	How many times a day do they take it?	When did they start taking this medicine?

Immunizations:

☐ The patient has all their immunizations
☐ Not sure if patient has all their immunizations
☐ We do not use immunizations

Did the patient's mother take medicine during her pregnancy? ☐ No ☐ Yes

List the medicine: ___________________________________

Were there any problems during pregnancy? ☐ No ☐ Yes

List the problems: ___________________________________

Were there any problems during the birth? ☐ No ☐ Yes

List the problems: ___________________________________

How much did the patient weigh when they were born? ________________________________

How long was the patient when they were born? _____________________________________

Was the patient ever called a preemie when they were born? ☐ No ☐ Yes

Has this patient grown and learned slower, faster, or about the same as other children?
☐ Slower ☐ Faster ☐ About the Same

Has this patient started to show signs of puberty, like teenage body changes?
☐ Unsure ☐ No ☐ Yes If yes, when did signs of puberty start? _______________

Has the patient ever had a menstrual cycle, also called a period? ☐ No ☐ Yes

If yes, how old were they when they got their first period? ________________

When was the date of their last period? ____________ How often do they get a period? _________

Patient Physical Health Information Section
Check the box if this patient has ever had trouble with any of the items below. On the line next to the problem, describe it.

- ☐ Skin concerns, spots, or birthmarks ______________________________
- ☐ Brain, nerves, headaches ______________________________
- ☐ Vision, hearing, taste, or smell ______________________________
- ☐ Heart or blood pressure ______________________________
- ☐ Breathing, asthma, or wheezing ______________________________
- ☐ Weight or height ______________________________
- ☐ Eating, swallowing, or appetite ______________________________
- ☐ Stomach, bowels, constipation or diarrhea ______________________________
- ☐ Kidneys, bladder, urination or peeing ______________________________
- ☐ Frequent infections
- ☐ Muscles or bones ______________________________
- ☐ Weakness or coordination ______________________________
- ☐ Blood or bleeding issues ______________________________
- ☐ Sleep issues, restlessness, snoring or ______________________________
- ☐ Activity / energy level ______________________________
- ☐ Sleep issues, restlessness, snoring or sleepwalking ______________________________

If the patient has ever stayed in a hospital, emergency room, or health facility to get medical care, list the information. If you need more room, write on the last page of the form.

Date	Reason for Hospitalization / ER	Name of Hospital City, State

If the patient ever had a surgery or procedure, list the information.

Date	Surgery / Procedure	Performed By	Where it was done (hospital/clinic name)

Patient Mental and Behavioral Health Information Section
Check the box if this patient has ever had a mental or behavioral health condition on the list below. On the line next to the condition, describe it.

- ☐ Depression ____
- ☐ Anxiety ____
- ☐ Suicidal attempt or thinking ____
- ☐ Other mental health conditions ____
- ☐ Eating Disorder(s) ____
- ☐ Drug use or overuse ____
- ☐ Alcohol use or overuse ____

If the patient has ever stayed in a mental health hospital, day, residential, or care program, list the information. If they were ever seen in an emergency room for mental health reasons, list that also.

Date	Reason for mental health hospitalization/ER/program	Name of Hospital, City, State

Patient School and Work
What grade is the patient in now? __________ What school is the patient at now?________________

How are the patient's grades in school this year?
☐ Better than last year ☐ About the same as last year ☐ Worse than last year

How many days of school did the patient miss in the last 6 months? ___________________

Have you talked to the school about the patient's gender identity? ☐ No ☐ Yes

What help does the patient's school have for gender non-conforming children and teens?

____

Has the patient ever worked? ☐ No ☐ Yes If yes, describe:

____

What kinds of things does the patient like doing?

____

What kinds of things does the patient do well or is good at?

____

What other things should we know to help take care of this patient?

____

Please write in information or check boxes to fill in rows about the patient's parents or guardians.

What are the parent or guardian goals?

____

____

Parent or Guardian 1	**Parent or Guardian 2**	**Parent or Guardian 3**
Name	**Name**	**Name**
Address	**Address**	**Address**
Phone	**Phone**	**Phone**
Type of work	**Type of work**	**Type of work**
Relationship to patient Mom ☐ Dad ☐ Step-parent ☐ Grandparent ☐ Foster parent ☐ Other family________☐	**Relationship to patient** Mom ☐ Dad ☐ Step-parent ☐ Grandparent ☐ Foster parent ☐ Other family________☐	**Relationship to patient** Mom ☐ Dad ☐ Step-parent ☐ Grandparent ☐ Foster parent ☐ Other family________☐
Status Married or Partnered ☐ Single ☐ Divorced ☐ Widowed ☐	**Status** Married or Partnered ☐ Single ☐ Divorced ☐ Widowed ☐	**Status** Married or Partnered ☐ Single ☐ Divorced ☐ Widowed ☐
Lives with patient Yes ☐ No ☐	**Lives with patient** Yes ☐ No ☐	**Lives with patient** Yes ☐ No ☐
Spends time with patient Yes ☐ No ☐	**Spends time with patient** Yes ☐ No ☐	**Spends time with patient** Yes ☐ No ☐
Has legal custody of patient Yes ☐ No ☐	**Has legal custody of patient** Yes ☐ No ☐	**Has legal custody of patient** Yes ☐ No ☐
Does the patient have siblings? Yes ☐ No ☐ If yes, please list names and ages of siblings.		

Family Member Health Information Section
We ask questions about family member health to know how to care for the patient.

Check the box next to the medical condition and who in the family has it.

Medical condition		Family member
☐	Diabetes	☐Mom ☐Dad ☐Sibling ☐Grandparent ☐Aunt or Uncle or Cousin
☐	Seizures or Epilepsy	☐Mom ☐Dad ☐Sibling ☐Grandparent ☐Aunt or Uncle or Cousin
☐	Early heart disease or stroke	☐Mom ☐Dad ☐Sibling ☐Grandparent ☐Aunt or Uncle or Cousin
☐	Migraines	☐Mom ☐Dad ☐Sibling ☐Grandparent ☐Aunt or Uncle or Cousin
☐	Kidney issues	☐Mom ☐Dad ☐Sibling ☐Grandparent ☐Aunt or Uncle or Cousin
☐	Cancer	☐Mom ☐Dad ☐Sibling ☐Grandparent ☐Aunt or Uncle or Cousin
☐	Psychiatric issues	☐Mom ☐Dad ☐Sibling ☐Grandparent ☐Aunt or Uncle or Cousin
☐	Liver issues	☐Mom ☐Dad ☐Sibling ☐Grandparent ☐Aunt or Uncle or Cousin
☐	Blood issues, such as easy bleeding or blood clots	☐Mom ☐Dad ☐Sibling ☐Grandparent ☐Aunt or Uncle or Cousin
☐	Mental Health (depression, anxiety, drug or alcohol, other mental health problems)	☐Mom ☐Dad ☐Sibling ☐Grandparent ☐Aunt or Uncle or Cousin

What worries do you or the other parents or guardians have for the patient?

- ☐ Behavioral issues
- ☐ Bullying/teasing/harassment
- ☐ Cigarette smoking
- ☐ Conflict at home
- ☐ Depression
- ☐ Gender identity concerns
- ☐ Gender presentation concerns
- ☐ Social issues
- ☐ School performance/learning issues
- ☐ Substance abuse
- ☐ Suicidal thoughts or self-harm
- ☐ One or more traumatic events

☐ Other concerns: ____

Other Information

Check the boxes if you would like to know more about:

☐ A referral for mental health care
☐ Resources for parents or guardians
☐ School-related problems
☐ Legal things, like a name change

How did you hear about our clinic? ____

1. **Complete** the form.
2. **Send** the completed form to the clinic **by mail or fax**.
3. The **clinic will call you** to set up an appointment for your child.

The clinic must have the form **before** they can call you to set up an appointment.

To fax the form:	(414) 266-6749
To mail the form:	Children's Wisconsin Gender Health Clinic MS C520 / Suite 740 8915 W. Connell Avenue PO Box 1997 Milwaukee, WI 53226

It is important to fill in as much of the form as you can. We look forward to helping your child and family.

Thank you, Children's Gender Health Clinic

Use the space below to add any information that did not fit on the form.