



Gender Affirming Case History

Date _____

Name _____

Is it okay to address mail and leave messages using the name above? _____

Legal Name, if Different _____

Pronouns _____

Gender Identity _____ Sex Assigned at Birth _____

Date of Birth _____ Age _____

Address _____

Phone _____

Email Address _____

Occupation _____

Employer _____

Highest Level of Education Completed _____

Emergency Contact Phone _____

Name and Pronouns to Use with Your Emergency Contact _____

Native Language _____ Primary Language _____

Physician's Name/Address/Phone _____

Referral Source/How Did You Hear About Us? _____

Person Completing This Form _____ Relationship _____

Insurance:

Primary _____ Secondary _____

Policy # _____ Policy # _____

Group # _____ Group # _____

Subscriber Name _____ Subscriber Name _____

Subscriber Phone Number & Address _____

Subscriber DOB _____ Subscriber DOB _____

ADDITIONAL INFORMATION

1. Do you ever change your voice in specific situations? Yes No

If yes, how and in what situations? _____

2. Do you ever experience discomfort (e.g., strain, fatigue, dryness, "scratchy" voice, etc.)? Yes No

If yes, please explain _____

3. Which communication partners do you feel most comfortable speaking with? _____

4. What situations and settings do you feel most comfortable speaking in? _____

5. Are you undergoing hormone therapy? Yes No

If under hormone therapy, are there any side effects (e.g. calming, emotional liability, mental concentration, changes in voice, etc.)? Please explain _____

6. Are you on any other medications? Yes No Do they cause any side effects? Yes No

If yes, please explain _____

7. What qualities do you like about your current voice? _____

8. What qualities do you dislike about your current voice? _____

9. What would you like to change about your current voice? _____

10. Who and/or what do you want your voice to sound like? _____

11. What are your personal goals for using your voice (e.g. phone, social, etc.)? _____

12. Have you been treated by an SLP in the past? Yes No

If yes, please describe your experiences and/or results _____

Concerns or questions you would like to address with the staff? _____

Additional comments _____
