**Client Intake Form**

Name       Today’s Date

Legal Name if Different       Name on Insurance Card

Medicare Number       Medicare-Secondary Insurance Number

Date of Birth       Age       Height       Weight

Gender Identity       Sex Assigned at Birth       Pronoun

Current Gender Presentation

Full Address

Phone

Email

Occupation

Who Referred You

Name, Email, and Phone of Emergency Contact Person

1. What concerns do you have about your voice, speech, communication, or singing?

2. What goal(s) do you have regarding your voice, speech, communication, or singing?

3. Please check the appropriate box regarding any concern you may have about the congruency of your voice and gender identity and/or gender presentation:

    Being misgendered by others     Both

    Voice dysphoria regardless of interacting with others     Neither

4. If you have voice dysphoria, how severe is it currently?

5. Have you made any steps towards medical, surgical or social gender transition? Please write any services you are receiving and/or plan to seek in the coming months that involve your voice, face, throat, upper body, or required intubation? Please include dates or length of time.

6. Do you have vocal strain, hoarseness, breathing or other vocal health problems? If so, please describe:

7. Do you have any medical or mental health conditions or learning disorders of any kind, or surgeries that required intubation that you haven’t mentioned already? If so, please name them.

8. What medications are you taking for anything?

9. Regardless of gender, how much do you typically speak in your daily activities? Please check all that apply.

    Typical daily conversation     Prolonged voice use (4+ hrs / day)     Speaking over noise

    High phone use or conference calls     Leading meetings/trainings     Public speaking

    Teaching/lecturing     Calling out to people or pets     Cheering at concerts/sports     Reading aloud to children     Singing or acting     Talkative

    Other:

10. What sources of support do you have regarding gender issues? Please check all that apply.

    Significant other / spouse     Children     Parents

    Friends     Coworkers     Superiors at work

    Trans support group     Online friends or group     Spiritual community

    Psychotherapist     Psychotherapy group     Other:

11. Some factors affect a person's ability to practice and use their new voice skills. Please check YES or NO.

Will you have a place to practice privately?     Yes     No

Will you be able to speak to others with a modified voice?     Yes     No

Will you be able to speak to others with a modified voice AND get their feedback?     Yes     No

Do you have people close to you who do NOT support your voice work?     Yes     No

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