

# INDIANA UNIVERSITY TRANSGENDER HISTORY INTAKE QUESTIONNAIRE

**All information on this form is confidential and will be kept in a private and secure location.**

## IDENTIFYING INFORMATION

Legal name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Preferred name (if different than legal name): \_\_\_\_\_ Today's date: \_\_\_\_\_

Are you comfortable being contacted by:  Phone (home)  Phone (work)  Email

Home phone: \_\_\_\_\_ Is it OK to leave a message at this number?  Yes  No

Work phone: \_\_\_\_\_ Is it OK to leave a message at this number?  Yes  No

Email: \_\_\_\_\_

Emergency contact person: \_\_\_\_\_ Their phone: \_\_\_\_\_

**Please inform staff if your contact information changes.**

## REASON FOR SEEKING SPEECH SERVICES

Describe concerns relating to speech in order of importance.

	Concern	How long has this been a problem?
1.	_____	_____
2.	_____	_____
3.	_____	_____

Have you tried any treatments for this in the past (on your own or with another professional)?  No  Yes

If yes, please describe when, what you tried, and the results: \_\_\_\_\_

\_\_\_\_\_

Have you ever had a hearing test?  No  Yes Date: \_\_\_\_\_ Result: \_\_\_\_\_

Does your speech change depending on how much you use your voice? How?: \_\_\_\_\_

\_\_\_\_\_

Does your voice change when you are under stress? How? \_\_\_\_\_

\_\_\_\_\_

## MEDICAL HISTORY

Current medication (name + dose): \_\_\_\_\_  
*include herbs/supplements*

Allergies: \_\_\_\_\_

Surgeries, serious illnesses, injuries, and hospitalizations: \_\_\_\_\_ Date: \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Please check if you have ever had:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Allergies                     | <input type="checkbox"/> Chronic sore throat           | <input type="checkbox"/> Loss of voice               |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Difficulty breathing          | <input type="checkbox"/> Pain in ears                |
| <input type="checkbox"/> Chronic congested nose        | <input type="checkbox"/> Difficulty swallowing         | <input type="checkbox"/> Pain in jaw                 |
| <input type="checkbox"/> Chronic cough                 | <input type="checkbox"/> Ear infections                | <input type="checkbox"/> Ringing in the ears         |
| <input type="checkbox"/> Chronic headaches             | <input type="checkbox"/> Frequent need to clear throat | <input type="checkbox"/> Sensation of lump in throat |
| <input type="checkbox"/> Chronic heartburn/acid reflux | <input type="checkbox"/> Hearing loss                  | <input type="checkbox"/> Sinus problems              |
| <input type="checkbox"/> Chronic runny nose            | <input type="checkbox"/> Hoarseness                    | <input type="checkbox"/> Sleep apnea                 |

Have any individuals in your family had serious illnesses or speech/hearing problems? Describe:

\_\_\_\_\_  
\_\_\_\_\_

## OTHER FACTORS THAT MAY AFFECT VOICE

Daily intake of water and other non-caffeinated, non-alcoholic drinks (e.g., milk, juice): \_\_\_\_\_

		Approx. start	Approx. end		Current daily consumption
Caffeine	<input type="checkbox"/> Past	_____	_____	<input type="checkbox"/> Current	_____
<i>(coffee, tea, soft drinks, chocolate)</i>					

Alcohol	<input type="checkbox"/> Past	_____	_____	<input type="checkbox"/> Current	_____
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Smoking		Approx. start	Approx. end		Current daily consumption
• Tobacco	<input type="checkbox"/> Past	_____	_____	<input type="checkbox"/> Current	_____
• Marijuana	<input type="checkbox"/> Past	_____	_____	<input type="checkbox"/> Current	_____
• Crack/Cocaine	<input type="checkbox"/> Past	_____	_____	<input type="checkbox"/> Current	_____
• Amphetamines	<input type="checkbox"/> Past	_____	_____	<input type="checkbox"/> Current	_____
• Other	<input type="checkbox"/> Past	_____	_____	<input type="checkbox"/> Current	_____

**All information on this form, including answers in this section, is confidential. We do not discriminate on the basis of past or present drug use.**

Do you use your voice in your work? Describe: \_\_\_\_\_

Do you use your voice for recreation (singing, acting, etc.)? Describe: \_\_\_\_\_

### OTHER HEALTH PROFESSIONALS INVOLVED IN CARE

To assist in coordination of care, it is helpful to know about other health professionals you are seeing. **Other care providers will not be contacted without your permission**, unless there is a medical emergency.

Name of primary care provider (GP, nurse, etc.): \_\_\_\_\_

Phone: \_\_\_\_\_

Other care providers (specialists, counsellors, etc.)

	Name	Phone
1.	_____	_____
2.	_____	_____
3.	_____	_____

Other: \_\_\_\_\_

### OTHER RELEVANT INFORMATION

If there is additional information you would like us to know, please write in the space below:

**If you have any questions or concerns, please let us know.**

*adapted from intake forms used by several programs reviewed for the Trans Care Project*

# TRANSGENDER SELF-EVALUATION QUESTIONNAIRE

## How do you rate your voice? (overall)

Currently my voice is:

- Very female
- Somewhat female
- Gender neutral
- Somewhat male
- Very male

My ideal voice would sound:

- Very female
- Somewhat female
- Gender neutral
- Somewhat male
- Very male

### RATING SCALE

- 1 = never
- 2 = almost never
- 3 = sometimes
- 4 = almost always
- 5 = always

## How often do you experience the following?

		1	2	3	4	5	
F	1	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
P	2	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
E	3	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
F	4	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
P	5	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
F	6	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
F	7	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
E	8	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
E	9	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
E	10	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
P	11	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
F	12	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
F	13	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
P	14	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
P	15	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
E	16	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
F	17	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
P	18	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
P	19	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
F	20	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
P	21	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
P	22	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
F	23	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
E	24	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
E	25	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
E	26	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
P	27	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
E	28	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
E	29	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always
E	30	never	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	always