Signaling inclusion starts in the waiting room. Use the suggestions in this document to augment or modify your existing intake form to send the message that you are supportive of GLBT patients. Please note: This is not intended to replace intake forms.

Legal name ____________________________________________

Name I prefer to be called (if different) ___________________

Preferred pronoun ____________________________

**Gender Identity:** Check as many as are appropriate. (An alternative is to leave a blank line next to Gender, to be completed by the patient as desired)

- Female
- Male
- Trans Female (MTF)
- Trans Male (FTM)
- Other ___________________

Are your current sexual partners men, women, or both? ____________________________

In the past, have your sexual partners been men, women, or both? __________________

**What is your relationship status?**

- Single
- Legally married
- Domestic partner/civil union relationship
- Divorced/separated
- Widowed
- Other __________________________

**Living situation**

- Live alone
- Live with spouse or partner
- Live with roommate(s)
- Live with parents or other family members
- Other __________________________

*From Straight for Equality in Healthcare. Learn more at www.straightforequality.org/healthcare.*
Do any children live in your household?

☐ Yes  ☐ No

Sexual Orientation/ Identity

☐ Bisexual
☐ Gay
☐ Heterosexual/Straight
☐ Lesbian
☐ Queer
☐ Other (please feel free to explain) _____________________________________________
☐ Not sure

Do you currently use or have you used hormones (e.g., testosterone, estrogen, etc.)?

☐ Yes  ☐ No

Do you need any information about hormone therapy?

☐ Yes  ☐ No

Have you been tested for HIV?

☐ Yes  Most recent test: ______________________
☐ No

Are you HIV-positive?

☐ Yes When did you test positive? _____________
☐ No
☐ Don’t know

Do you need birth control?

☐ Yes  ☐ No

If yes, are you currently using birth control?

☐ Yes (please specify type) ____________________________
☐ No

Do you have any questions about sex or sexuality?

☐ Yes (you may state your question here or we can talk in person): ______________________
☐ No

Do you need to discuss any of the following with us? (check all that apply)

☐ Current safety concerns or a history of physical, sexual or emotional abuse
☐ Getting along with parents
☐ Getting along with friends or partner
☐ Privacy/confidentiality
☐ Loneliness, depression, anxiety or problems eating or sleeping
☐ Addiction, alcohol use, and/or tobacco use
☐ Weight, bodybuilding or eating concerns
☐ Safer sex or sexually transmitted diseases
☐ Pregnancy test or pregnancy options
☐ Other (please specify) _____________________________________________