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Clinical Sexologist

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Confidential Client Intake Form — for my use only

Date: ____________________

Name: ____

Email: ____

Phone: ____

Date of birth: ____

Relationship status: ______ single _______ in a relationship ______ married _______

______ separated _____ divorced _____ widowed/widower _____ other

Orientation: _____ heterosexual _____ homosexual _____ queer _____ bisexual _____ other

Gender Identity: ____

Preferred pronouns: ____

Referred by: ____

Children? ___________ Ages: ______________________ Living with you: ____________________

Describe your physical health: ____

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Pre-existing medical conditions: ____

What medications do you take? ____

Over-the-counter medications/supplements: ____

Have you ever had an STI? ____

Do you currently have an STI? ____

Recreational drugs/frequency: ____

How much alcohol do you drink per day? ____

How many cigarettes/e-cigarettes/vapes per day? ____

Do you have any sexually transmitted infections? ____

Have you sought treatment? ____

What are your goals for our work? ____

____

Cancellation Policy

I understand that if I need to cancel my appointment I must contact Dr. Rees at least 48 hours in advance or I must pay for the appointment.

____ date: ________________________