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Confidential Client Intake Form — for my use only

Date: _____

Name: _____

Referred by: _____

Email: _____

Phone: _____

Date of birth: _____

Relationship status: single ____ in a relationship ____ married ____ separated ____
divorced ____ widowed/widower ____ other ____

Orientation: heterosexual ____ homosexual ____ queer ____ bisexual ____
pansexual ____ asexual ____ demisexual ____ other ____

Gender Identity: ____

Preferred pronouns: _____

Children? ____ Ages: _____ Living with you: ____

Describe your physical health: _____

Pre-existing medical conditions: _____

What medications do you take? _____

Over-the-counter medications/supplements: _____

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? _____

Have you ever had a sexually transmitted infection? _____

Do you use contraception to prevent unwanted pregnancy? _____

What type(s) of contraception do you use _____

How often do you use contraception? _____

Do you use barrier protection from sexually transmitted infections? (e.g. condoms) _____

What type(s) do you use? _____

How often do you use barrier protection? _____

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: _____