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Sexual Health Questionnaire

-- If answering any question makes you uncomfortable, it is OK to leave it blank --

Today's Date: ______________________________

Name:____

Who do you live with?____

What is your relationship status (i.e. single, partnered, etc.)?____________________________

Which gender(s) do you have sex with?____

Do you use birth control and/or STI protection? If so, what method(s)?____________________

What prompted you to come in at this time?____

Who initiated seeking therapy? Any previous treatment?_______________________________

____

What is the problem(s)?____

When did it/they first begin?____

What was happening in your life at that time of onset?________________________________

____

How have you (or you and your partner(s)) attempted to handle the problem(s) to date?_______

____

What was helpful and what was not?____

____

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Under what circumstances have they worked? (people, situations, locations, time, thoughts, feelings)____

____

Where and when does the problem(s) get better? Get worse?____________________________

____

Alcohol/substance use/abuse? How often and how much do you or your partner(s) use?______

____

What medications including over the counter do you use?________________________________

____

Any chronic illnesses? Any surgeries, and/or injuries to your abdomen, pelvis, nervous system including brain, reproductive system or genitalia? ______________________________________

____

If therapy is successful, what will you be able to do that you are unable to do now?

____

How will this change your relationship?____

How does this problem(s) affect your partner's sexual functioning?________________________

____

What significance does the problem(s) have with respect to your own sexual functioning?

____

Any downside(s) if this problem(s) goes away?____________________________________

____

What is your motivation for changing?____

____

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