Female Important Data and Questionnaire

Name: _____ Age: _____

Current Concerns

In your own words, what are the main reasons for which you are seeking help?		
Please check all that apply:		
□ Sexual concerns	□ Personal / emotional issues	□ Financial issues
□ Relationship / marital	□ Crisis / trauma	□ Stress
□ Job / vocational	□ Health issues	□ Depression / anxiety
□ Other:		
Please list the most stressful current events in your life:		

Relationship History

Please list names of partners in previous marriages / long-term partnerships and provide a brief summary of your relationship with each partner (use additional pages if needed):

Medical History

Primary Care Physician (PCP):
List medical problems:
Medications / Dose:

Childhood History

As a child did you have any problems with:	
Learning disabilities □ Y □ N	Depression □ Y □ N
Hyperactivity □ Y □ N	Sexual or physical abuse □ Y □ N
Bed wetting □ Y □ N	Anxiety or other fears □ Y □ N
School fears □ Y □ N	Obsessions or Compulsions □ Y □ N
Significant life trauma(s) including losses, and ages at which they occurred	

Family of Origin History

	Mother	Father
Current age, or if deceased, age and cause of death		
Use three adjectives to describe each parent	1. 2. 3.	1. 2. 3.
Describe your relationship to each parent		
Describe your earliest memory of either parent		
Use three adjectives to describe their marriage	1. 2. 3.	
Length of their marriage		
Caption that describes your family of origin		
Number of siblings		
Your place in birth order		
Were you adopted?	□ Y □ N	
Divorce and remarriage of your parents:		
Your age at divorce		

Reason for divorce	
Relationship to step-parents, if any	
List any major family of origin problems	

Substance Use and Behavior History

Substance / Activity	Amount / frequency
□ Alcohol	
□ Tobacco	
□ Drugs	
□ Marijuana	
□ Medications (not as prescribed)	
□ Reckless behavior	
□ Gambling	
□ Violent history	
□ Convictions for felonies	
Do you or does your spouse, friend, or loved one believe any of these substances or behaviors are a problem in your relationship or work life?	□ Yes □ No

Mental Health History

Is there a self/family history of any of the following problems? (Check all that apply):	
Problem	
□ Alcoholism	□ Self □ Family / Relationship to self:
□ Substance abuse	□ Self □ Family / Relationship to self:
□ Depression	□ Self □ Family / Relationship to self:
□ Suicide (or attempts)	□ Self □ Family / Relationship to self:
□ Panic attacks	□ Self □ Family / Relationship to self:
□ ADD	□ Self □ Family / Relationship to self:
□ Bipolar disorder	□ Self □ Family / Relationship to self:
□ Eating disorders	□ Self □ Family / Relationship to self:

Mental health hospitalizations of self or family members

Name	Relationship	Problem

Please state any other personal mental health history: (medications, previous diagnoses, therapy, length of time with therapist, name of therapist)

Social Contacts

Do you have a friend or family member that you regularly talk to about your life concerns?	□ Y □ N
Do you participate in regular social activities?	□ Y □ N
Do you participate in a religious or faith-based group?	□ Y □ N

Symptom checklist

Please read the following list carefully and check any conditions that you currently experience.

Select the number "1" if you are experiencing mild difficulty with an item, and "2" if you are experiencing moderate to severe difficulty.

Leave an item blank if you do not experience this difficulty.

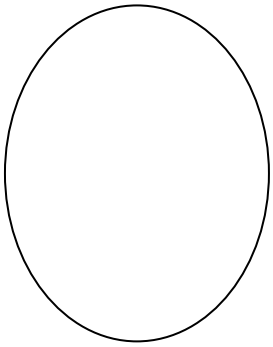
□ Insomnia 1 2	□ Sensitivity to bright lights 1 2
□ Oversleeping 1 2	□ Premenstrual problems 1 2
□ Restless sleep or waking early 1 2	□ Irregular menstrual cycle 1 2
□ Loss of appetite 1 2	□ Headaches 1 2
□ Increased appetite 1 2	□ Dizziness 1 2
□ Rapid weight loss or gain 1 2	□ Fainting 1 2
□ Frequent crying or feeling weepy 1 2	□ Rapid heartbeat 1 2
□ Frequently sad 1 2	□ Frequent indigestion 1 2
□ Frequently irritable 1 2	□ Overweight 1 2
□ Described as angry by loved ones 1 2	□ Diarrhea 1 2
□ Feeling empty 1 2	□ Constipation 1 2
□ Feeling abandoned 1 2	□ Teeth grinding 1 2
□ Tired most of the time 1 2	□ Jaw pain 1 2
□ Loss of interest socially 1 2	□ Throws up food 1 2
□ Unable to make decisions 1 2	□ Purges with laxatives 1 2
□ Worrying much of the time 1 2	□ Constrains food intake 1 2
□ Described as pessimistic 1 2	□ Feels fat 1 2
□ Unable to enjoy usual interests 1 2	□ Seeing things that are not there 1 2
□ Problems with decision making 1 2	□ Hearing voices 1 2
□ Difficulty concentrating 1 2	□ Smell odors that are not present 1 2
□ Sometimes panicky 1 2	□ Experiences déjà vu 1 2
□ Increasingly anxious 1 2	□ Loss of time 1 2
□ Dislike for weekends/holidays 1 2	□ Specific fears (specify) 1 2
□ Uncomfortably shy 1 2	□ Obsessive or intrusive thoughts 1 2
□ Low self-esteem and self-worth 1 2	□ Repeating compulsive behaviors (like washing hands) 1 2
□ Difficulty making friends 1 2	□ Gambles to excess 1 2
□ Unable to relax 1 2	□ Problems with alcohol 1 2
□ Sexual satisfaction low 1 2	□ Problems with drugs/medications 1 2
□ Loss of interest in sex 1 2	□ Problems with reckless behavior 1 2
□ Other sexual concerns 1 2	□ Violent impulses 1 2
□ Pain with sexual intercourse 1 2	□ History of violence 1 2
□ Problems with pornography 1 2	□ Homicidal thoughts 1 2
□ Unpleasant dreams (recurring) 1 2	□ Suicidal thoughts 1 2

Sex Questionnaire

1. How long have you been in your current relationship? _____
2. What is your primary sexual orientation? Hetero Lesbian Bi-sexual
3. In your own words, what is the sexual problem?

4. When did the problems begin?

5. Do you have orgasms? Yes No
6. What percentage of the time do you have orgasms in any way when you make love? __%
7. If never, have you ever had an orgasm? Yes No
8. Can you have them by yourself? Yes No No experience with masturbation
9. Do you have any pain with intercourse? Yes No
10. Have you experienced trouble w/ full penetration by a partner? Yes No
11. If yes, have you ever successfully used a tampon? Yes No
12. Have you been able to tolerate a gynecological exam? Yes No
13. Have you experienced any form of penetration with comfort? (Your own or partner's fingers?) Yes No
14. Do you have any genital pain other than w/ intercourse? Yes No
15. If yes, where is the pain? (have your clinician draw a map)



16. What does the pain feel like?

17. Is there any pain post-intercourse? Yes No If yes, how long does it last? _____

18. What have you tried to alleviate the pain at this point?

19. Are you adequately aroused when you begin intercourse – good vaso-congestion or swelling and natural or artificial lubrication? Yes No
20. How many times per month do you think about sex in a positive way? (see a romantic movie, read a romantic book, hear a song that reminds you, have a dream, thoughts, fantasies) _____ per month
21. How many times per week do you think about sex in a negative way? (i.e., worries that partner will initiate or want sex?) _____per week
22. Does your partner share equally in household and/or childcare responsibilities? Yes No
23. Does your partner listen to you? Yes No
24. Does your partner respect you? Yes No
25. Are you sexually attracted to your partner? Yes No
26. Are you and your partner generally affectionate with each other at times other than sex? (cuddle, kiss hello/good-bye, hold hands?) Yes No
27. Do you believe your partner is sexually attracted to you? Yes No
28. Does your body image impact your sexual experience? If so, how?

29. Do you wash your genitals in the shower with your hands or a washcloth?
30. Does your partner have any sexual problems, past traumas, inhibitions or difficulty with performance?

31. Do you take any medication that might have sexual side effects? Yes No
32. Are you using birth control pills? Yes No
33. Have you had your hormones tested? Yes No
34. Results of Free Testosterone? _____
35. Are you post-menopausal? Yes No Are you using any HRT? Yes No

36. Any medicated creams?

37. List all medication and doses:

38. Are you depressed or anxious? Yes No
39. How have you managed these feelings before coming to therapy?

40. When you make love, how long does the whole experience last? _____
41. How long does your partner stimulate your clitoris? _____
42. Is the sexual encounter sexy and erotic or boring and routine? (circle)
43. How frequently would you prefer to have sex? _____
44. How frequently would your partner prefer to have sex? _____
45. How many times have you had sexual relations in the last month? _____
46. Between you and your partner, who initiates sexual contact usually? How? Is this an acceptable balance to you?

47. How would you rate your partner's skill as a lover from 1-10 (10 high) _____
48. Is your partner a good kisser? Yes No
49. How willing is your partner to learn and grow as a lover? 1-10 (10 high) ____
50. Does your partner desire any sexual acts or expressions that make you uncomfortable? Yes No, What?_____

51. Describe any traumatic sexual experiences and the ages that they occurred.

52. Describe how, if at all, the messages of spirituality or faith impact your sexuality.

53. Describe sex before the problems began.

54. Describe your early childhood messages surrounding sexuality.

55. Were your parents affectionate with each other? With you?

56. Describe your first sexual experience.

57. Do you have any sexually transmitted diseases?

58. Circle any sexual activities that you find offensive, uncomfortable, immoral and in any way objectionable for any reason:

Hugging tightly	Intercourse on top
Being seen nude	Intercourse on bottom
Kissing	Intercourse from behind
French Kissing	Use of a vibrator
Breasts caressed	Anal touching
Stomach caressed	Anal sex
Buttocks caressed	Sexual fantasies involving partner
Genitals touched	Sexual fantasies involving other than partner
Sexually explicit language	Acting out sexual fantasies w/ partner
Masturbation	Partner's sexual fantasies
Receiving oral sex	Pornography used by partner
Giving oral sex	Pornography used by couple
Clean-up after sex	Partner preferences
Sex during menstrual cycle	