Male 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

Please answer with short answers where appropriate or use a 1-5 scale with 1 being "none or very little" and 5 being "a lot or usually."

_____ 1. How enjoyable are sexual activities for you?

_____ 2. How much passionate love do you feel for your partner(s)?

_____ 3. Rate your sexual attraction to your partner.

_____ 4. How much companionable love do you feel for your partner?

_____ 5. How much resentment do you feel toward your partner?

_____ 6. Are you satisfied with your partner(s) as a lover?

_____ 7. Have you ever have difficulty reaching climax during sexual activity?

_____ 8. Have you ever ejaculated without any pleasurable sensation in your penis?

_____ 9. Have you had trouble getting an erection before intercourse begins?

_____ 10. Have you had trouble keeping an erection once intercourse has begun?

_____ 11. Have you experienced any pain during intercourse?

_____ 12. How long ago did these problems begin?

_____12.5 Have you had the same problems regardless of the partner?

_____ 13. Does your partner experience difficulty in sexual desire/arousal?

_____ 14. Do you ever reach orgasm with minimal sexual stimulation before or shortly after penetration?

_____ 15. About how many times have you had sexual activities this last month?

_____ 16. Do you have a current sex partner?

17. Check your sexual orientation? __Heterosexual __Homosexual __Bi

18. Describe your early childhood messages surrounding sexuality.

19. Describe the messages of spirituality or faith, as they may have or do now impact your sexuality.

20. Describe your first sexual experience.

21. Describe any traumatic sexual experiences with the ages that they occurred.

22. Between you and your partner, who initiates sexual contact usually? How? Is this an acceptable balance to you?

23. Please list any medication used consistently including vitamins and herbs.

Medication	Dose

_____ 24. Do you have any sexually-transmitted diseases?

_____ 25. Do you use pornography to an extent that you or your partner feel is problematic?

_____ 26. Do you act on other sexual impulses that you or your partner think might jeopordize your primary relationship?

_____ 27. Do you desire sexual activities that your partner is uncomfortable doing? If yes, please list:

_____ 28. Does your partner desire sexual activities that you are uncomfortable doing?

If yes, please list: