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Center for Intimacy & Sexuality

Name: ______________________________ DOB:___________

Additional Demographic Information

Please list name, relation, and birth date of any children and other household members (use back of page for additional space):

Name / Relation/Birth date	Gender Identity	Lives with you
		□ Y □ N
		□ Y □ N
		□ Y □ N
		□ Y □ N
		□ Y □ N

Who referred you to us or how did you find out about Awakenings?

If you were referred by an individual, may we contact them to thank them for referring you? □ Y □ N

Cancellation Policy

We require a full 48 hours notice for cancellation or rescheduling, or the full fee for the appointment will be charged to your credit card. **Please initial cancellation policy**: ___________

Name on credit card	Credit card number	Expiration Date	3 digit code

Important Data and Questionnaire

Current Concerns

In your own words, what are the main reasons for which you are seeking help?

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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:

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Medications / Dose: (including cremes, vitamins, or mineral supplements)

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

	Parent ____________________	Parent____________________
Current age, or if deceased, age and cause of death		
Use three adjectives to describe each parent	1. 2. 3.	1. 2. 3.

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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		

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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:

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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

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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

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Sex Questionnaire

Please answer the questions that pertain to you and skip the questions that do not.
Some questions are on a scale from 1 to 10, with 10 being the highest.

1. What word would you use to describe your primary sexual orientation? __________
2. Do you consider yourself to be transgender? Yes No
3. What pronouns do you prefer? ____________
4. Monogamy question?
5. Do you have a current sexual partner?
6. In your own words, what is the sexual problem?
7. When did the problems begin?
8. What have your done to alleviate the problem?
9. Do you have orgasms? Yes No
   a. If yes, how satisfying would you rate them (1-10) _______
10. What percentage of the time do you have orgasms in any way when you make love? __%
11. If never, have you ever had an orgasm? Yes No
12. Can you have them by yourself? Yes No No experience with masturbation
13. Have you ever had difficulty reaching climax during sexual activity? Yes No
    a. If yes, what percentage of the time? ____________%
14. Do you ever reach orgasm with minimal sexual stimulation before or shortly after penetration? Yes No
15. Have you ever ejaculated without any pleasurable sensation in your penis? Yes No NA
16. Do you have any pain with intercourse? Yes No
17. Have you experienced trouble w/ full penetration by a partner? Yes No
    a. If you use them, have you ever successfully used a tampon? Yes No
    b. Have you been able to tolerate a gynecological exam? Yes No
    c. Have you experienced any form of penetration with comfort? (Your own or partner's fingers?) Yes No NA
18. Do you have any genital pain other than w/ intercourse? Yes No

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19. If yes, where is the pain?

20. What does the pain feel like?

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

22. (?)Are you adequately aroused when you begin intercourse – good vaso-congestion or swelling and natural or artificial lubrication? Yes No

    a. If you do use lubrication, what do you use? ______________
    b. Are you satisfied with it? Yes No

23. Have you had trouble getting an erection before intercourse begins? Yes No NA
24. Have you had trouble keeping an erection once intercourse has begun? Yes No NA
25. 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
26. 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
27. How long have you been in your current relationship? _________
28. How equally does your partner share in household and/or childcare responsibilities (1-10)? ______
29. How much do you feel your partner listen to you (1-10)? _______
30. How much do you feel your partner respect you (1-10) ? _______
31. How much are you sexually attracted to your partner (1-10)? ______
32. Are you and your partner generally affectionate with each other at times other than sex? (cuddle, kiss hello/good-bye, hold hands?) Yes No
33. Do you believe your partner is sexually attracted to you? Yes No
34. Does your body image impact your sexual experience? If so, how?

35. Do you wash your genitals in the shower with your hands or a washcloth? (circle)
36. Does your partner have any sexual problems, past traumas, inhibitions or difficulty with performance?

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37. Do you take any medication that might have sexual side effects? Yes No
38. Are you using birth control pills? Yes No
39. Have you had your hormones tested? Yes No
40. Results of Free Testosterone? ______
41. Are you post-menopausal? Yes No NA
    a. Are you using any HRT? Yes No
42. Do you have any sexually transmitted diseases? Yes No
    a. If yes, what? __________
43. Are you depressed or anxious? Yes No
44. How have you managed these feelings before coming to therapy?

45. How much passionate love do you feel for your partner (1-10)? ______
46. Rate your sexual attraction to your partner (1-10) _______
47. How much companionable love do you feel for your partner (1-10)? ______
48. How much resentment do you feel toward your partner (1-10)? _____
49. Are you satisfied with your partner(s) as a lover? ______
50. When you make love, how long does the whole experience last? _______
51. How long does your partner stimulate your clitoris? _______
52. Is the sexual encounter sexy and erotic or boring and routine? (circle)
53. How frequently would you prefer to have sex? ______
54. How frequently would your partner prefer to have sex? _____
55. How many times have you had sexual relations in the last month? _______
56. Between you and your partner, who initiates sexual contact usually? How? Is this an acceptable balance to you?

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

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

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

63. Describe sex before the problems began.

64. Describe your early childhood messages surrounding sexuality.

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

66. Describe your first sexual experience.

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

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

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