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Yara A. Perez, LCPC, CST
HOLISTIC PSYCHOTHERAPY

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FEMALE BRIEF SEXUAL HISTORY

PATIENT NAME: _____ Date of Birth: _____

Street Address: _____

City/State/Zip: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Ok to send Mail? ☐ Yes ☐ No Ok to call? ☐ Yes ☐ No

Relationship status: ☐ Single ☐ Divorced ☐ Married ☐ Separated ☐ Other:_____

Present sexual identity: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transvestite ☐ CD ☐ Transsexual
☐ Other:_____

Present living situation: ☐ Alone ☐ with my spouse ☐ with a lover ☐ with friends ☐ with a roommate
☐ with my parents ☐ Other:_____

Age of 1st sexual feeling:_____ Age of 1st erotic dream: _____Age of 1st masturbation: _____
Age of 1st sexual attraction:_____ Age of 1st date:_____ Age of 1st sexual intercourse:_____
Age of 1st orgasm: _____ Age of 1st period: _____ Date of last orgasm: _____

Age of menopause: _____ Type of hormone supplement used: ☐ RX ☐ Natural/OTC _____
How long hormone supplement used? _____

WRITE BRIEF ANSWERS:

1) What childhood messages about sex/sexuality did you receive? Of those, how might they affect your sexuality today?

2) What are any concerns you may have about your periods or pregnancy?

3) What are any concerns you may have about being pre-, peri-, post-menopausal?

4) What have been your experiences with achieving orgasm? Alone? With a partner?

5) What have been your experiences with self-pleasuring or masturbating yourself?

6) What is your present pattern and frequency for self-pleasuring/masturbation?

7) How did and how do you feel about your body (as a child, growing up, as a young adult, and now)?

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8) Describe the history of your sexual relationships: (Use extra paper if you need to. Talk about the number of partners, what sexual activities you have experienced, and the issues and conflicts that have emerged for you in intimate relationships.)

9) Describe any feelings you may have about having sexual contact with your present or possible sexual partner(s):

10) Describe your present sexual interactions, such as intercourse or masturbation, turn-ons, your present pattern for sexual pleasure, how often, your current number of partners, etc.:

11) How often do you think about or desire to have sex?
- ☐ once a day
- ☐ more than 4 times a day
- ☐ once a week
- ☐ more than 4 times a week
- ☐ less than 4 times a month

12) Check below any of these which are sexual "turn-on's" for you:
- ☐ erotic/porno magazines
- ☐ erotic porno videos
- ☐ fantasy during masturbation
- ☐ phone sex lines
- ☐ massage parlors
- ☐ Online sex chats
- ☐ Internet sex (live)
- ☐ other online sex with others
- ☐ prostitutes
- ☐ male escorts
- ☐ BDSM play
- ☐ cross dressing
- ☐ swinging clubs/parties
- ☐ exotic dance clubs/strip clubs
- ☐ voyeurism
- ☐ exhibitionism
- ☐ erotic books
- ☐ romance novels
- ☐ dirty talk
- ☐ Other: _____

13) Are you interested in being trained in bodywork, such as masturbation or other sexual enhancement techniques? ☐ Yes ☐ No

14) Do you have any pre-existing medical conditions that may affect your sexuality (for example, diabetes, hypertension, heart disease, etc.)? ☐ Yes ☐ No

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15) Are you currently taking any prescribed medications, such as for hypertension, diabetes, depression, anxiety or cardiovascular disease? ☐ Yes ☐ No

16) Do you drink or smoke more than moderately or use recreational drugs? ☐ Yes ☐ No

17) Are you interested in using safe, natural products that can enhance your sexual experience? ☐ Yes ☐ No

18) What are your long-term sexual goals?

19) What is your primary goal for our work together?

20) Write here anything else related to your past or present experiences. Include anything that may be important for me to know, so that I may assist you toward reaching your sexual goals: