

**JoAnn Kraft, MA**  
**The Carriage House**  
**4300 Baker Road**  
**Minnetonka, MN 55343**  
**952-912-9800**

## **Sexual History**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Age:** \_\_\_\_\_

**Education level:** (Circle one) High School    Some College    College Graduate  
Post College Education

**Marital Status:** (Circle one) Single    Cohabiting    Engaged    Married    Divorced    Widowed  
If married, how long?

**Previous relationships** (over 1 year, cohabitation, engagement or marriage):  
How long were you together?    Why and how did it end?

- 1.
- 2.
- 3.
- 4.

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### **Health questions**

When was your last physical exam?

Tests done and results:

Health issues:

As a child:

As an adolescent:

As an adult:

Surgeries (birth to present):

Current medications:

Name	Dosage	Reason for taking
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Substance use:

Amount

Frequency

Tobacco

Alcohol

Non-prescription drugs

Supplements/vitamins

Other

Previous counseling:

Age

Issue

Length of counseling

Results

Are you experiencing any of the following?

depressed mood

difficulty concentrating

anxiousness

fatigue

sadness

irritability

hyperactivity

forgetfulness

difficulty sleeping

suicidal thoughts

frequent anger

tearfulness

change in weight

gender issues

self injuring behaviors

compulsive behaviors

grief

feelings of shame

feelings of panic

withdrawal from family

eating disturbance

**Chief concern for this visit:**

Other issues:

Personal

Relational (spouse, boy/girlfriend, partner)

Family (parents, siblings, children)

What would you like to have change?

How happy are you with life?

## Family History

Parents:

Mother

Age:

Marital Status: Single Married Divorced Remarried Widowed

Marital Satisfaction:

General Health:

Relationship status with you:

Any significant information that I should know:

Father

Age:

Marital Status: Single Married Divorced Remarried Widowed

Marital Satisfaction:

General Health:

Relationship with you:

Any significant information that I should know:

Stepparents

Age:

Relationship with you:

Age:

Relationship with you:

Siblings

Age:

Gender:

Relationship quality:

Age:

Gender:

Relationship quality:

Age:

Gender:

Relationship quality:

Age:

Gender:

Relationship quality:

Children

Age:

Gender:

Relationship quality:

Age:

Gender:

Relationship quality:

Age:

Gender:

Relationship quality:

Age:

Gender:

Relationship quality:

Family Issues I Should be Aware of:

**For women:**

Age of onset of menses (period): \_\_\_\_\_

Describe any difficulties with menstruation:

Do you experience PMS or other menstrual difficulties?

Issue	Severity	Treatment
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Reproductive history:

Pregnancies

Miscarriages

Abortions

Infertility

What type of birth control do you use? Difficulties with?

Describe any difficulty you have or have had with:

Breasts

Genitals

Vagina

Uterus/cervix

Urethra or bladder (including incontinence)

Rectum

How do you feel about your body?

Have you ever had issues with eating? (anorexia/ bulimia)

Has anyone ever touched you in a way that made you uncomfortable?

Who and when?

How did you react?

How was it dealt with?

Have you ever been abused (emotionally, sexually, physically)

If so, when and by whom?

How did you react?

How was it dealt with?

Age of first intercourse: \_\_\_\_\_

With whom?

How many sexual partners have you had? \_\_\_\_\_

**For men:**

Age of first ejaculation: \_\_\_\_\_

Wet dreams, masturbation or sex play with another person?

Describe any difficulty you have or have had with:

Breasts

Penis

Testicles

Rectum

Prostate

Age of first intercourse?

With whom?

How many sexual partners have you had? \_\_\_\_\_

How have you masturbated in the past (method/location)?

How often did you masturbate as an adolescent?

How often are you masturbating now?

Has anyone ever touched you in a way that made you uncomfortable?

Who and when?

How did you react?

How was it dealt with?

Have you ever been abused (emotionally, sexually, physically)

If so, when and by whom?

How did you react?

How was it dealt with?

## **Sexual Knowledge**

How did you learn about sex? (from whom, at what age, how did it affect you?)

When were you first exposed to explicit sexual activity?

Television

Movies

Magazines

Saw someone masturbating

Saw someone having sex

What is your level of sexual knowledge at present?

What is your partner's level of sexual knowledge?

Do you and your partner talk about your sex life? How comfortable are you with the discussions?

Pornography exposure and use:

When did you first see pornography?

What type?

How often do you use pornography currently?

What type?

Have you ever been addicted to pornography or had its use adversely affect your life?

Same sex experience:

Have you ever had same sex desires?

Experiences:

Feelings about same sex attraction or interaction:

STDs:

Have you ever had a sexually transmitted disease?

If so, what and how was it treated?

Birth control:

If you are in a relationship, are you using birth control, if so, what type?

## Current Sexual Issues

Satisfaction with current relationship:

How would you describe your  
Desire level:

Frequency of arousal:

Frequency of sexual behavior:

Current

What would you like?

Who initiates?

How?

Orgasm:

Frequency

How is it stimulated?

Is there any pain with sexual activity?

Location

Intensity

Recent changes in sexuality:

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How would you describe your partner's

Desire level:

Frequency of arousal:

Frequency of sexual behavior:

What would he/she like?

Orgasm:

Pain experience:

Recent changes in sexuality:

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How are the changes affecting your relationship?

What have you tried to improve your sexual relationship?

Describe your sexual activity:

Initiation –

Foreplay –

Genital contact –

Insertion -

Intercourse –

Orgasm -

Afterglow –

At what point does the difficulty occur?

Do you or your partner ask for certain behaviors during sex?

Do you agree on what sexual behaviors are ok?

Do you coach each other during sex?

When is the best time of day for sex?

What are the distractions?

What sexual activities are most pleasing to you?

How would you like the following to be different?

Foreplay –

Initiation –

Genital contact –

Insertion -

Intercourse –

Orgasm -

Afterglow –

Type of sexual behaviors currently experiencing:

Genital

Oral

Anal

Other (describe)

None

What sexual activities are causing problems for you?

Are you having sexual contact with anyone other than your partner? If yes, does your partner know?

What type of sexual fantasies do you have?

Are you sexually attracted to your partner?

### **Additional Information**

Are there any religious or spiritual influences on your sexuality either growing up or now?

How would you describe yourself?

How would you describe your partner?

