Client Sexuality Intake Form

Date: _____

Name: _____

1. What does sexuality mean to you?

2. On a scale of 1-10 what is your sexual activity level? (Select one)

   (Least active) 1 2 3 4 5 6 7 8 9 10 (Very active) Select

3. Do you have any negative attitudes toward sex due to culture or religious beliefs? (If so, what are they?)

4. How do you identify yourself in regard's to sexual orientation?

5. What would you like to accomplish through sexuality coaching?

6. What are some difficulties you have experienced in your sexual relationships in the past six months?

7. Have you ever experienced problems with arousal?

8. How did you get through them?

9. What are your thoughts about masturbation?

10. Do you masturbate? (If yes, how often?)

11. What do you use to masturbate? (your hand, toys, your partner's hand etc.)

12. Do you feel comfortable talking about sex with your current or past partners?

13. Do you feel comfortable asking for what you want and need sexually?

14. How do you feel about sexual experimentation?

15. Do you consider yourself to have a more or less permissive attitude about sexuality?

For Men:

1. Do you have problems with erections and /or early ejaculation?

2. Does it ever take longer than you would like or expect to ejaculate?

3. What is your preferred method to orgasm? (Oral vs. penetration)

For Women:

1. Do you experience difficulties with your ability to orgasm (externally, internally)?

2. What is your preferred method to orgasm? (Oral vs. penetration)

3. Is sex ever painful? (If yes, please explain)

4. Are you currently on any form of birth control? (If yes, please list)

Women and Men:

1. What are your sexual fantasies and fetishes (If any)?

2. Do you share them with your partner? (If no, please explain why not?)

3. What are your turn-ons?

4. What are your turn-offs?

Health:

1. Have you ever been treated for sexuality problems in the past? If yes what was your response to treatment?

2. Are you currently on any medications that may inhibit your sex drive? (For example high blood pressure medication, psych. Medications, etc.)

3. Do you drink? (If yes, how often)

4. Do you smoke? (If yes, how often?)

5. Do you exercise? (If yes, how often?)

Please email completed client intake form to: ***mlikescoaching@gmail.com***