Couples Relationship-Sexuality Intake Form

Date: __________________

Name: ____

Name of Partner: ____

1. How long have you been in your current relationship?

2. What would you like to accomplish through coaching?

3. What difficulties have you experienced in the relationship within the past six months?

4. What is your method of conflict resolution?

5. Have you attended couples therapy in the past and if so how did it help?

6. What are your biggest strengths and weaknesses as a couple?

7. Please rate your current level of relationship happiness by selecting the number that corresponds with your current feelings about the relationship. (Select one)

   (Extremely unhappy) 1 2 3 4 5 6 7 8 9 10 (Extremely happy)

8. What is your current level of stress (in the relationship)? (Select one)

   (No stress) 1 2 3 4 5 6 7 8 9 10 (High stress)

9. What is your current level of personal stress (overall)? (Select one)

   (No stress) 1 2 3 4 5 6 7 8 9 10 (High stress)

10. When do you feel most content in your relationship?

11. When do you feel most unhappy or frustrated?

12. How enjoyable is your sexual relationship? (Select one)

    (Extremely unpleasant) 1 2 3 4 5 6 7 8 9 10 (Extremely pleasant)

13. How satisfied are you with the frequency of your sexual relations? (Select one)

    (Extremely unsatisfied) 1 2 3 4 5 6 7 8 9 10 (Extremely satisfied)

14. What do you find most satisfying about your sexual relationship?

15. How has your sexual relationship changed since you were first together?

16. Do you believe that within your relationship one of you has a problem with sexual drive or getting aroused? (If yes, who and list the concern)

17. Are any of your sexual problems possibly related to stress, like change in job, moving, birth of a child, death of a loved one, relationship distress, etc.?

18. Do you feel comfortable talking about sex with your partner?

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

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 you preferred method to orgasm?

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. Do you feel confident in your knowledge about your body's sexual anatomy and functioning?

2. What are your thoughts about masturbation?

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

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

5. Do you have sexual fantasies or fetishes? (If yes, please list)

6. Have you shared your thoughts with your partner? (If no, why not?)

7. Does your partner have any behaviors that you have difficulty accepting or getting aroused by? (If yes, please explain)

8. Do you like to watch porn?

9. How often?

10. What are some of your favorite scenes? What scenes do you dislike?

11. How do you feel about sexual experimentation?

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

13. Are there any outside social views, or religious views that prevent you from experiencing sexual freedom in the relationship?

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 couples intake form to: ***mlikescoaching@gmail.com***