

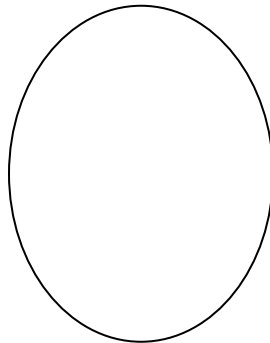
Female Sex Questionnaire

Name: _____ Age: _____

1. How long have you been in your current relationship? _____
2. What is your primary sexual orientation? Hetero Lesbian Bi-sexual
3. In your own words, what is the sexual problem?

4. When did the problems begin?

5. Do you have orgasms? Yes No
6. What percentage of the time do you have orgasms in any way when you make love?
 ____%
7. If never, have you ever had an orgasm? Yes No
8. Can you have them by yourself? Yes No No experience with masturbation
9. Do you have any pain with intercourse? Yes No
10. Have you experienced trouble w/ full penetration by a partner? Yes No
11. If yes, have you ever successfully used a tampon? Yes No
12. Have you been able to tolerate a gynecological exam? Yes No
13. Have you experienced any form of penetration with comfort? (Your own or partner's fingers?) Yes No
14. Do you have any genital pain other than w/ intercourse? Yes No
15. If yes, where is the pain? (have your clinician draw a map)



16. What does the pain feel like?

17. Is there any pain post-intercourse? Yes No – how long does it last? _____
18. What have you tried to alleviate the pain at this point?

19. Are you adequately aroused when you begin intercourse – good vaso-congestion or swelling and natural or artificial lubrication? Yes No
20. 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
21. 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
22. Does your partner share equally in household and/or childcare responsibilities?
Yes No
23. Does your partner listen to you? Yes No
24. Does your partner respect you? Yes No
25. Are you sexually attracted to your partner? Yes No
26. Are you and your partner generally affectionate with each other at times other than sex? (cuddle, kiss hello/good-bye, hold hands?) Yes No
27. Do you believe your partner is sexually attracted to you? Yes No
28. Does your body image impact your sexual experience? If so, how?

29. Do you wash your genitals in the shower with your hands or a washcloth?
30. Does your partner have any sexual problems, past traumas, inhibitions or difficulty with performance?

31. Do you take any medication that might have sexual side effects? Yes No
32. Are you using birth control pills? Yes No
33. Have you had your hormones tested? Yes No
34. Results of Free Testosterone? _____
35. Are you post-menopausal? Yes No Are you using any HRT? Yes No

36. Any medicated creams?

37. List all medication and doses:

38. Are you depressed or anxious? Yes No
39. How have you managed these feelings before coming to therapy?

40. When you make love, how long does the whole experience last? _____
41. How long does your partner stimulate your clitoris? _____
42. Is the sexual encounter sexy and erotic or boring and routine? (circle)
43. How frequently would you prefer to have sex? _____
44. How frequently would your partner prefer to have sex? _____
45. How many times have you had sexual relations in the last month? _____
46. Between you and your partner, who initiates sexual contact usually? How? Is this an acceptable balance to you?
47. How would you rate your partner's skill as a lover from 1-10 (10 high) _____
48. Is your partner a good kisser? Yes No
49. How willing is your partner to learn and grow as a lover? 1-10 (10 high) _____
50. Does your partner desire any sexual acts or expressions that make you uncomfortable?
Yes No, What? _____

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

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

53. Describe sex before the problems began.

54. Describe your early childhood messages surrounding sexuality.

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

56. Describe your first sexual experience.

57. Do you have any sexually transmitted diseases?

58. 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