



Diane Gleim

Licensed Marriage and Family Therapist
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Sexual Health Questionnaire

-- If answering any question makes you uncomfortable, it is OK to leave it blank --

Today's Date: _____

Name _____

Your preferred pronouns: _____

Who do you live with? _____

What is your relationship status (i.e. single, dating, partnered, married, in open/poly relationship, CNM, etc.)?

Which gender(s) do you have sex with? _____

Do you use birth control and/or STI protection? If so, what method(s)? _____

What prompted you to come in at this time? _____

Who initiated seeking therapy? Any previous treatment? _____


What is the problem(s)? _____

When did it/they first begin? _____

What was happening in your life at that time of onset? _____

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How have you (or you and your partner(s)) attempted to handle the problem(s) to date?

What was helpful and what was not? _____

Under what circumstances have they worked? (people, situations, locations, time, thoughts, feelings)

Where and when does the problem(s) get better? Get worse? _____


Alcohol/substance use/abuse? How often and how much do you or your partner(s) use?

What medications including over the counter do you use? _____

Any chronic illnesses? Any surgeries, and/or injuries to your abdomen, pelvis, spine, nervous system including brain, reproductive system or genitalia?

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If therapy is successful, what will you be able to do that you are unable to do now?

How will this change your relationship? _____


How does this problem(s) affect your partner's sexual functioning? _____

Any downside(s) if this problem(s) goes away? _____

What is your motivation for changing? _____

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