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**Short Sexual History Questionnaire**

**Basic Information**

**Provide only the information you’re comfortable having me utilise to contact you and/or send information to:**

|  |  |
| --- | --- |
| Name: | E-mail Address: |
| Address: | Mobile Phone: |
| Other Phone: | Date of Birth: |
| Gender: | Gender of Current Partners: |
| Relationship/s Status: | Sexual Orientation: |
| Spirituality/Religion (if currently practicing): | I heard about your services through: |

**ISSUES**

**Currently, I am experiencing (check all that apply):**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Lack of arousal |  | Difficulty achieving orgasm |
|  | Erectile difficulty |  | Lack of genital sensation |
|  | Boredom in my sex life |  | Inability to sexually satisfy myself |
|  | Pain upon intercourse |  | Poor body-image |
|  | Inability to sexually satisfy my partner |  | Inability to communicate about my sexual needs |
|  | Reliance on troublesome fantasies or turn-ons |  | Fears around sexual contact or activities |
|  | Delayed or rapid ejaculation (circle one) |  | Decreased sense of connection with partner |
|  | Vaginal dryness |  | Other: |

**Are you seeing a doctor for any of the above?**

**If you answered yes to #3, would you like me to be in touch with them to better meet your needs? If so, please provide the name and contact details of your doctor:**

**Name:**

**Contact:**

**RELATIONSHIP**

**If you are currently in a relationship, does your partner know you are seeking counselling sessions? If not, please explain:**

 **If you are currently in a relationship, would you be interested in including your partner in this process?**

 **If you are currently in a relationship, do you think your partner would be interested in participating in this process?**

**OBJECTIVES**

**Your learning objectives for the sessions might be:**

**Where you want to focus first is:**

**What you need from me is:**

**Please add anything else you think is important for me to know.**