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INITIAL ASSESSMENT:
Form 3

SEXUAL EVALUATION

Name: _____

Date:_____

Completing this form is vital to the sexual retraining/therapy process and will give you as a couple and your therapist a complete picture of the sexual patterns you hope to change in order to enjoy a mutually satisfying sex life in your marriage.

Who referred you to us?

What particular sexual difficulty are you experiencing?

How is it affecting:

You:

Your spouse:

When and how did this problem first develop?

What have you done about it (counselling, reading, self help etc.)?

Which one of you initiated this process to work on your dilemma?

DETAILS OF YOUR SEXUAL EXPERIENCE:

Frequency:

Desire:

Initiation: (Who? How? When? Where? How would you like it different?)

Your Sexual Process: What actually happens? How is it for you?

Kissing:

Total body caressing:

Breasts:

Genitals: (Response to being touched; response to your spouse's genitals)

Entry: (Who determines? When does it occur? How does it feel?)

Arousal: (What stimulates? Any problems?)

For him:

For her:

Orgasm (when):

For him:

For her:

What sexual activities cause conflict between the two of you?

What are your feelings following intercourse?

What happens after intercourse?

How would you like your sexual life to be? (Your goals)

What difference would those changes make:

For you as a person?

For your relationship as a couple?