THE OFFICE OF

Dr. Christopher Ryan Jones PsyD

*Clinical Psychologist • Sex Therapist*

# CLIENT INTAKE INFORMATION

| Client Name | Date |
|---|---|
| | |

Preferred Name

## PRESENTING PROBLEM

- Briefly describe the issues/problems

- How severe, on a scale of 1–10, do you rate your presenting problems?

  MOST SEVERE 1 2 3 4 5 6 7 8 9 10 LEAST SEVERE

- How long has this problem been causing distress? (please circle)

  ❑One month ❑1–6 Months ❑6 Months – 1 Year ❑ Longer than one year

- How do you rate their current level of coping on a scale of 1–10?

  UNABLE TO COPE 1 2 3 4 5 6 7 8 9 10 ABLE TO COPE

## PERSONAL INFORMATION

- How do you identify your gender?

  ❑Male ❑Female ❑Male-Female ❑Female-Male ❑Non-binary

- Comments:

- What is your ethnicity?

❑ American Indian/Indigenous ❑ Asian ❑ Hispanic/Latino ❑ Indian

❑ Black/African American ❑ Caucasian ❑ Multi-racial

❑ Native Hawaiian/Pacific Islander ❑ Other

- Where were you born? City: Country:

## EMPLOYMENT

- Are you currently employed? ❑ YES or ❑ NO
- If yes, what is your occupation?
- If not currently employed, what was your occupation?

## EDUCATION

- Are you currently enrolled in school? ❑ YES or ❑ NO
- What is your highest level of education?

❑ High School / GED ❑ Vocational Training ❑ College

❑ Grad School ❑ Other

- Marital Status (more than one answer may apply):

❑ Single ❑ Married ❑ Partnered ❑ Dating

❑ Engaged ❑ Widowed ❑ Separated ❑ Divorce in process

❑ Live-In Partner ❑ Significant ❑ Other

- Length of time in current relationship: Total number of marriages:
- Assessment of current relationship (if applicable): ❑ Great ❑ Good ❑ Fair ❑ Poor
- How would you describe yourself in social relationships (at school, work, with friends):

❑ Affectionate ❑ Aggressive ❑ Avoidant ❑ Follower

❑ Leader ❑ Friendly ❑ Outgoing ❑ Shy / Withdrawn

Other (Please Specify):

- Do you have any specific relationship concerns? ❑ YES or ❑ NO

If yes, please specify:

## SEX AND SEXUALITY

- What is your sexual orientation?

  ❑ Heterosexual ❑ Gay Male ❑ Lesbian ❑ Bisexual

  ❑ Transgender ❑ Questioning ❑ I'd rather not say_____

- Are you currently experiencing sexual concerns? (sexual desire concerns, difficulty with arousal or orgasm, sexual pain, gender or sexual orientation concerns, etc.) ❑ YES or ❑ NO
- If yes, please describe:
- Is your partner currently experiencing sexual dysfunctions? ❑ YES or ❑ NO
- If yes, please describe:
- Do you have any positive or negative experiences about sex early in your life?

  ❑ YES or ❑ NO
- Where, when, and from who did you learn about sex?
- Did you experience any sexual abuse at any age? ❑ YES or ❑ NO
- Were you exposed to inappropriate sexual material at any age? ❑ YES or ❑ NO
- What were your feelings about puberty?
- How did you feel about the changes in your body?
- How regularly do you masturbate?
- How did you feel about it?
- Do you use pornography? ❑ YES or ❑ NO
- How often?
- How did you feel about it?

- Did you ever or do you now have an illness that affects your sexuality or your relationships? ❑ YES or ❑ NO

Please specify:

- Did you feel comfortable or insecure about your sexuality as an adolescent? ❑ YES or ❑ NO
- Did you have any relationships lasting more than a few months? ❑ YES or ❑ NO
- Did they include sexual activity? ❑ YES or ❑ NO
- If so, was it pleasurable? ❑ YES or ❑ NO
- Was there ever, at any age, an unwanted pregnancy? ❑ YES or ❑ NO
- Did you have many /a few /no sexual partners before your current relationship? ❑ YES or ❑ NO
- Have you had any relationships that included satisfying sex? ❑ YES or ❑ NO
- What made them satisfying?
- Have you had any relationships in which you were dissatisfied? ❑ YES or ❑ NO
- What made them unsatisfactory?
- Do you believe that within your relationship one of you has a problem with sexual drive? ❑ YES or ❑ NO
- What about arousal (getting turned on)? ❑ YES or ❑ NO
- Do you feel comfortable talking about sex within your relationship? ❑ YES or ❑ NO
- Do you feel comfortable asking for what you want and need sexually? ❑ YES or ❑ NO

## FOR MEN

- Do you have problems with erections and / or early ejaculation? ❑ YES or ❑ NO
- Does it ever take longer than you would like or expect to ejaculate? ❑ YES or ❑ NO

## FOR WOMEN

- Do you experience difficulties with your ability to orgasm (externally, internally)?

  ❑ YES or ❑ NO
- Is sex ever painful? ❑ YES or ❑ NO
- When, where?
- Does it prevent you from having sex? ❑ YES or ❑ NO

## MEN AND WOMEN

- Do you feel confident in your knowledge about your body's sexual anatomy and functioning? ❑ YES or ❑ NO
- Are there areas about your body and/or your sexual functioning that you have questions about? ❑ YES or ❑ NO
- If so, what questions would you like to have answered?
- Do you have sexual fantasies? ❑ YES or ❑ NO
- Do you enjoy them, or not? ❑ YES or ❑ NO
- Do you share them? ❑ YES or ❑ NO
- Do you have any sexual behaviors (e.g., a fetish) that interfere with sexual enjoyment with yourself or your partner? ❑ YES or ❑ NO
- Does your partner have any behaviors that you find difficulty accepting or getting aroused by? ❑ YES or ❑ NO
- Are there questions about your gender or orientation that you would like to explore? ❑ YES or ❑ NO
- 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.? ❑ YES or ❑ NO
- If you have a spiritual life, what does or does not support your exploration of your sexuality?

- Tell me about any interactions with healthcare providers regarding sexual concerns.
- Did they go well? ❑ YES or ❑ NO

- Tell me about attitudes toward sex in your culture / culture of your family of origin.

- In what ways was your family more or less permissive?

- What attitudes do you have about how people of any gender are supposed to act in a sexual relationship? For example, are men supposed to be the initiators?

- How do you think your sexual development has been influenced by ideas you have read about or learned of in the media? ❑ YES or ❑ NO

- What are your beliefs about the place of sexuality in a person's life?

- What are your beliefs about the place of sexuality in a person's relationships?

- How do you feel about sexual experimentation?

- Do you consider yourself to have a more or less permissive attitude about sexuality?
  ❑ MORE or ❑ LESS

## LEGAL

- Are you currently involved in any active legal cases (traffic, civil, criminal)? ❑ YES or NO

  If Yes, please describe and indicate the court and hearing/trial dates and charges:

## HOBBIES / INTERESTS

- Describe your areas of special interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, religious activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

- What do you do for yourself as self-care activities?

- List any recent health or physical changes within the last year:

## MEDICAL HISTORY

- Family history of medical or psychological problems:

- Do you use any of the following chemical? (if yes, quantity)

  ❑ Alcohol ❑ Illegal Drugs ❑ Caffeine ❑ Nicotine ❑ Over the counter

  Quantity:

- Prescription drugs (name, dosage and usage):

- Counseling/Prior Treatment History

| | |
|---|---|
| When: | Where: |
| For how long: | With whom: |
| For what: | |
| | |

- Have you participated in a drug/alcohol treatment program? ❑ YES or ❑ NO

If yes, please explain:

- Have you ever been hospitalized for mental concerns? ❑ YES or ❑ NO

If yes, please explain:

- Have you been involvement with self-help programs? ❑ YES or ❑ NO

If yes, please explain: (Examples: AA, Al-Anon, NA, Overeaters Anonymous)

- Have you had suicidal thoughts and/or attempts: ❑ YES or ❑ NO

If yes, explain:

Do you feel suicidal at this time? ❑ YES or ❑ NO

If yes, explain: