Sexual History-Male

(This confidential Questionnaire is required when working with Denise Wiesner, L. Ac.)

Date:

Name:

Residence Address:

City, State, Zip:

Indicate primary telephone: H or W or Cell #:
Email:

Billing address if different:
Address:
City, State, Zip:

Credit Card Information:
Type of card to be charged: VISA/MC/AMEX/DISCOVER/other
CC# Exp. Date: __/__/__
Prefer Paypal: Yes/No

Ok to send Mail? Yes/No Ok to call? Yes/No

Date of Birth:

Present sexual identity: Heterosexual/ Homosexual/ Bisexual/ Asexual/CD/ Trans/ Poly/BDSM/Other

Age of 1st sexual feeling: _____ Age of 1st wet dream: _____
Age of 1st masturbation:_____ Age of 1st sexual attraction: _____
Age of 1st date: _____ Age of 1st sexual intercourse: _____
Age of 1st orgasm: _____ Date of last orgasm: _____

Write brief answers:

1.What are any concerns you may have about your sexuality right now? Why are you here (For example, feelings about your sexual performance, feelings that lovemaking has gone south since trying to conceive, feelings about your relationship, your body)?

2.What childhood messages about sex/sexuality did you receive? Of those, how might they affect your sexuality today?

3.What are any concerns you may have about being male?

4.What have been your experiences with achieving orgasm? Alone? With your partner?

5.What have been your experiences with self-pleasuring or masturbating yourself?

6.What is your present pattern and frequency for self-pleasuring/ masturbation?

7.How did and how do you feel about your body (as a child, growing up, as a young adult and now)?

8.Describe the history of your sexual relationships: (Take extra paper or use other side if you need to; talk about the number of partners, what sexual activities you have experienced, and the issues and conflicts that have emerged for you in intimate relationships.)

9.Describe any feelings you may have about having sexual contact with your present or possible sexual partner(s):

10.Describe your present sexual interactions, such as intercourse or masturbation, turn-on's, your present pattern for sexual pleasure, how often. Has this changed since trying to conceive?

11.How often do you <u>think about or desire</u> to have sex?
___1x/ day ___ more than 4x's/day
___1x/ week ___ more than 4x's/ week
___less than 4x's/ month

12)Are you and your partner's sexual frequency satisfying to you?

13.Check below any of these which are sexual "turn-on's" for you:

___ erotic/ porn magazines	___ erotic/ porn DVDs
___ fantasy during masturbation	___ phone sex
___ massage parlors	___ online sex chats
___ Internet porn (live)	___ online or cybersex with others
___ prostitutes	___ B/D/S/M play
___ cross dressing	___ swinging clubs/parties/lifestyle
___ exotic dance clubs	___ voyeurism
___ poly lifestyle	___ "dirty talk"

___ erotic books ___ romance novels
Other: _____ _____

14.Are you currently seeing a psychotherapist Yes or No

15.Do you have any pre-existing medical conditions that may affect your sexuality? Yes or No

16. Have you been evaluated by a Urologist? Yes or No

17.Are you currently taking any prescribed medications, such as for hypertension, diabetes, depression, anxiety or cardiovascular disease? If so please list:

18.Do you drink more than moderately or use recreational drugs? Yes or No

19. What are your long-term sexual goals?

20. What is your primary goal for our work together?

21. Are you willing to commit to your sexual success, do you agree to do the assignments and allow yourself to your sexual pleasure? Yes – No – Not sure

22) Write here anything else related to your past or present experiences. Include anything that may be important for me to know, so that I may assist you toward reaching your sexual goals:

I hereby release Denise Wiesner L. Ac. and Natural Healing & Acupuncture , Inc for any damages that may result from sexual coaching : _____ initials