

# Female Sexual Questionnaire

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

1. How long have you been in your current relationship? \_\_\_\_\_
2. What is your primary sexual orientation? (Hetero) (Lesbian) (Bi-sexual) (Bi-curious)
3. In your own words – what is the sexual problem? \_\_\_\_\_  
\_\_\_\_\_
4. When did the problems begin? \_\_\_\_\_
5. **Do you have orgasms? (Yes) (No)**
6. **If no, have you ever had an orgasm? (Yes) (No)**
7. **Can you have them by yourself? (Yes) (No) (No experience with masturbation)**
8. **What percentage of the time do you have orgasms when you make love? \_\_\_\_\_%**
9. **Do you have any pain with intercourse? (Yes) (No)**
10. Have you experienced trouble w/ full penetration by a partner? (Yes) (No)
11. If yes, have you ever successfully used a tampon? (Yes) (No)
12. Have you been able to tolerate a gynecological exam? (Yes) (No)
13. Have you experienced any form of penetration with comfort (your own or partner's fingers)? (Yes) (No)
14. Do you have any genital pain other than w/ intercourse? (Yes) (No)
15. If yes, where is the pain? \_\_\_\_\_  
\_\_\_\_\_
16. What does the pain feel like? \_\_\_\_\_  
\_\_\_\_\_
17. Is there any pain post-intercourse, how long does it last? \_\_\_\_\_
18. What have you tried to alleviate the pain at this point?  
\_\_\_\_\_
19. Are you adequately aroused when you begin intercourse (good vaso-congestion or swelling and natural or artificial lubrication)? (Yes) (No)
20. **How many times per month do you think about sex in a positive way? For example, when you see a romantic movie, read a romantic book, hear a song that reminds you of sex, has a dream, thoughts, fantasies: \_\_\_\_\_ per month**
21. **How many times per week do you think about sex in a negative way? For example, worrying that partner will initiate or want sex? \_\_\_\_\_ per week**
22. Does your partner share equally in household and/or childcare responsibilities? (Yes) (No)
23. Does your partner listen to you? (Yes) (No)
24. Does your partner respect you? (Yes) (No)
25. Are you sexually attracted to your partner? (Yes) (No)
26. Are you and your partner generally affectionate with each other at times other than sex? For example, you cuddle, kiss hello/good-bye, hold hands? (Yes) (No)
27. **Do you believe your partner is sexually attracted to you? (Yes) (No)**
28. **Does your body image impact your sexual experience? If so, how?**  
\_\_\_\_\_  
\_\_\_\_\_
29. **Do you wash your genitals in the shower with: (Hands) (Washcloth)?**

**30. Does your partner have any sexual problems, past traumas, inhibitions or difficulty with performance?**

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- 31. Do you take any medication that might have sexual side effects? (Yes) (No)
  - 32. Are you using birth control pills? (Yes) (No)
  - 33. Have you had your hormones tested? (Yes) (No)
  - 34. Results of Free Testosterone? \_\_\_\_\_ (please bring a copy of results to appointment).
  - 35. Are you post-menopausal? (Yes) (No)
  - 36. Are you using any HRT? (Yes) (No)
  - 37. Any medicated creams? (Yes) (No)
  - 38. List all medication and their doses:
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- 39. Are you depressed or anxious? (Yes) (No)
  - 40. How have you managed these feelings before coming to therapy?
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- 41. When you make love, how long does the whole experience last? \_\_\_\_\_
  - 42. How long does your partner stimulate your clitoris? \_\_\_\_\_
  - 43. How is the sexual encounter: (sexy and erotic) or (boring and routine)
  - 44. How frequently would you prefer to have sex? \_\_\_\_\_
  - 45. How frequently would your partner prefer to have sex? \_\_\_\_\_
  - 46. How many times have you had sexual relations in the last month? \_\_\_\_\_
  - 47. Between you and your partner, who initiates sexual contact usually? How? Is this an acceptable balance to you? \_\_\_\_\_
  - 48. How would you rate your partner's skill as a lover from 1-10 (10 high) \_\_\_\_\_
  - 49. Is your partner a good kisser? (Yes) (No)
  - 50. How willing is your partner to learn and grow as a lover? 1-10 (10 high) \_\_\_\_\_
  - 51. Does your partner desire any sexual acts or expressions that make you uncomfortable? (Yes) (No) What? \_\_\_\_\_
  - 52. Describe any traumatic sexual experiences by the ages that they occurred:
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53. Describe how if at all, the messages of spirituality or faith impact your sexuality:

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54. Describe sex before the problems began: \_\_\_\_\_

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55. Describe your early childhood messages surrounding sexuality?

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56. Were your parents affectionate with each other? With you?

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57. Describe your first sexual experience? \_\_\_\_\_

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58. Do you have any sexual transmitted diseases? \_\_\_\_\_

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59. Circle any sexual activities that you find offensive, uncomfortable, immoral and in any way object to for any reason:

- Hugging tightly
- Being seen nude
- Kissing
- French Kissing
- Breast caressed
- Stomach caressed
- Buttocks caressed
- Genitals touched
- Sexually explicit language
- Masturbation
- Receiving oral sex
- Giving oral sex
- Clean-up after sex
- Sex during menstrual cycle
- Intercourse on top
- Intercourse on bottom
- Intercourse from behind
- Use of a vibrator
- Anal touching
- Anal sex
- Sexual fantasies involving partner
- Sexual fantasies involving other than partner
- Acting out sexual fantasies w/ partner
- Partner's sexual fantasies
- Pornography used by partner
- Pornography used by couple