The New Breath Counseling Center, Inc.
Cell: 1-908-251-0464
www.rincon-counseling.com

Virtual Counseling

Sex Therapy In-take Form

Please complete this form as fully and openly as possible. All private information is held in the strictest confidence within legal limits. ***If certain questions do not apply, leave them blank. If you need help completing this form, please do not hesitate to ask.*** *Thank you for your cooperation.*

Today's Date:_____

Name:_____Age: _____ Gender: M F X Race/Ethnicity:_____
Birth Date:_____Social Security #:_____
Mailing Address:_____
County:_____ City:_____State:_____ Zip:_____
We may need to call you to remind you of an appointment or to change an appointment. May we leave a message? (Circle One) Yes No
What is the best number to leave a message or to contact you?_____

Partner/Spouse Name:_____Age:_____ Gender: M F X
Race/Ethnicity:_____ Birth Date:_____Social Security #:_____
Mailing Address:_____
County:_____ City:_____State:_____ Zip:_____
We may need to call you to remind you of an appointment or to change an appointment. May we leave a message? (Circle One) Yes No
What is the best number to leave a message or to contact you?_____

In case of an emergency:
Name of local friend or relative (not living at the same address):_____
Relationship to client:_____ Home Phone:_____
Cell Phone:_____ Work Phone:_____

Are you currently receiving counseling services elsewhere: [ ] Yes [ ] No
If yes, please describe with who and the reason:_____
_____

Have you ever been to counseling as a result of problems with this relationship prior to today?_____ If so, what was the outcome of that counseling? _____
_____

Are you currently experiencing sexual concerns (sexual desire concerns, difficulty with arousal or orgasm, sexual pain, gender or sexual orientation). ___ Yes ___No

Is your partner currently experiencing sexual difficulties? ___ Yes ___ No (If yes describe difficulties).__

_____

_____

Have either you or your partner been in individual counseling before?_____ If so, give a brief summary.

_____

_____

What is/are the main reason for this visit?_____

What are your goals or what do you hope to accomplish from sex therapy counseling?

_____

_____

How would you rate the severity of your problem: _ Low _ Moderate _ Severe _Very Severe _ Don't Know

What is your current level of stress? (Circle one)

Very high High Moderate Low Very low Extremely low

Has either of you threatened to separate or divorce as a result of the current sexual problems? __Yes __No

Have either you or your partner consulted with a lawyer about divorce?_____ If yes, who?___

_____

Do you perceive that either you or your partner has withdrawn from the marriage? _____ If yes, which of you have withdrawn?_____

Please answer the following questions:

I have considered suicide in the past (circle one): Yes No. If yes, please give a brief description with dates.

_____

_____

I have attempted suicide recently or in the past (Circle one): Yes No. If yes, please give a brief description with dates. _____

_____

Have you **considered suicide** in connection to your **current** problem? Circle One) Yes No
If so, please give a brief description with dates:_____

_____

I have had homicidal thoughts recently or in regard to my current problem (Circle one): Yes No. If yes, please give a brief description with dates. _____

_____

I have considered homicide in the past (Circle one): Yes No. If yes, please give a brief description with dates. _____

_____

OCCUPATIONAL:

Current means of financial support (circle all that apply):

Self Family Spouse Children Retirement Benefits Public Assistance Disability

Employment Status:

Employed: ___ Full-time ___Part-time ___Unemployed ___Disabled ___Retired ___Student

Current Employer:_____ Phone#:_____

Your current position:_____ Date Began:_____

Describe your current working environment:_____

_____

Children:

NAME	MALE/FEMALE	AGE

Are there custody issues? ____ Yes ____No. If yes, please explain:_____

_____

_____

Who has custody of your children?_____

FAMILY HISTORY:

Were you reared (raised) by someone other than your parents? ___Yes ___No. If yes, who?_____

_____

How many siblings do you have?_____ Where are you in birth order? (I. e. first, second, youngest, etc.)_____

_____

Do/did your father/mother favor any particular child? If so who and why?_____

_____

How did your family communicate affection?_____

How was sexuality discussed in the home while growing up?_____

_____

Were both parents open and assessable to questions about sexual concerns? ___ Yes ___ No

RELATIONSHIP HISTORY:

Current status: ____Single ____Separated ___Widowed ___Married ___Divorced ___Remarried

Have you at any time separated from your present spouse/partner: ___ Yes ___ No

Please describe your marital or other significant relationship._____

_____

How long have you been married/been a couple to your present partner?

Did you and your partner live together before marriage? ___ Yes ___ No If yes, how long:_____

Please rate your current level of happiness by circling the number which corresponds with your current feelings about the relationship.

0	1	2	3	4	5	6
Extremely Unhappy	Fairly unhappy	A Little unhappy	Happy	Very happy	Extremely happy	Perfect

Do you believe that within your relationship one of you has a problem with sexual drive?_____What about arousal (being turned on)?_____

How do you contribute to the difficulties in the relationship? _____

_____

Have you had any sexual problems in past marriages or relationships: (If so, what kind) ___ Yes ___ No_

_____

How important is sex to you in this relationship?_____

Do you and your partner/spouse talk openly about sex?_____

Have you been able to get what you wanted from sex?_____

Do you feel comfortable asking for what you want and need sexually?_____

What are you prepared to do differently in the relationship? _____

_____

To what degree do you have family or friends that support you as a couple? (Circle one)

Extremely high Very high High Moderate Low Very low Extremely low

On a scale 1-10 rate the following (1- completely dissatisfied, 10- completely satisfied)

General Relationship	1	2	3	4	5	6	7	8	9	10
Couple time alone	1	2	3	4	5	6	7	8	9	10
Social activities (together)	1	2	3	4	5	6	7	8	9	10
Occupation/Academic Progress	1	2	3	4	5	6	7	8	9	10
Communication	1	2	3	4	5	6	7	8	9	10
Financial issues	1	2	3	4	5	6	7	8	9	10
Household/yard Responsibilities	1	2	3	4	5	6	7	8	9	10
Parenting	1	2	3	4	5	6	7	8	9	10
Daily Social Interaction	1	2	3	4	5	6	7	8	9	10
Trusting Each Other	1	2	3	4	5	6	7	8	9	10
Decision Making	1	2	3	4	5	6	7	8	9	10
Resolving Conflict	1	2	3	4	5	6	7	8	9	10
Support of one another	1	2	3	4	5	6	7	8	9	10

SEXUAL HISTORY:

Please indicate your sexual orientation: __Heterosexual __Homosexual __ Bi-sexual ___Transgender ___Asexual __Unsure ___Other

Do you use pornography?___ Yes ___ No. How often?_____

Do/did you ever have an illness that affected your sexuality or your relationship?_____

ABUSE HISTORY:

Have you or your partner struck, physically restrained, used violence against or injured the other person within the last three years?_____ If yes for either, who, how often and what happened. _____

_____

Have you been a victim of any of the following types of abuse? If yes, please indicate by whom, the duration, and your age at the time of the abuse.

		By Whom?	Duration	Your Age
Physical Abuse	___Yes ___No			
Sexual Abuse	___Yes ___No			
Emotional Abuse	___Yes ___No			
Neglect/Abandonment	___Yes ___No			

Have you ever abused anyone? _____ Yes _____ No. If yes, please describe._____

_____

Have you ever been a victim of ANY other crime? _____ Yes _____No. If yes, please describe._____

_____

SUBSTANCE USE/HABITUAL BEHAVIOR:

Do you use nicotine? ____Yes ____No Type: ____Cigarettes ____Cigars ____Smokeless
How long have you used nicotine?_____ How much per day?_____
Do you use alcohol? __ Yes __ No. If yes, how frequent?_____How much each time?_____
Type of use: ____Social ____Recreational ____Abusive _____Problematic ____Addicted
If you do not use alcohol have you in the past? ____Yes ____No If yes, how frequent?_____
Do you currently or have you in the past used street drugs or abused prescription drugs? ___Yes ___No.
Details_____

MEDICAL HISTORY:

Are you under the care of a psychiatrist?___Yes ___No If yes, whom?_____

Please list any medical conditions:_____

_____

HOSPITALIZATIONS (PHYSICAL OR MENTAL HEALTH):

Hospital	Dates	Reason

OUTPATIENT MENTAL HEALTH TREATMENT:

Facility/Therapist	Dates	Reason

Allergies:_____

MEDICATIONS:

Medication	Dosage	Reason	Prescribing Physician

EDUCATION:

Highest educational level reached:_____

RELIGION:

What is the name of your religion, if any?_____

Do your religious beliefs influence the decisions you make regarding sexual matters? ___ Yes ___ No

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payments at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

I hereby consent to treatment by specified provider. I understand that I have a right to discontinue or refuse treatment/services at any time.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

Acknowledgement of receipt of Notice of Private Practice Form:
I acknowledge receipt of a copy of the Notice of Private Practice Form.

_____ _____
Client Signature Date

_____ _____
Client Signature Date