

Intake Questionnaire – Sexual Therapy

Before you begin

- This questionnaire helps you prepare for the first session and gives me an initial orientation. Completing it is optional.
- Only answer what you wish to share in writing. Any question can be left open and discussed in person instead.
- You can complete the questionnaire on screen or on paper and bring it to your first session. Please do not send it by unencrypted email.
- All information is covered by my professional confidentiality. This questionnaire is not a consent form; information on the treatment framework and data protection is provided separately.
- In an acute crisis, please call 112 immediately. In Sweden you can also call 1177 for healthcare advice around the clock.
- If you come as a couple, it is best for each person to complete their own questionnaire. Questions about intimate experiences are especially optional – you decide how much you share in writing.

1. About you

Name

Date of birth

Phone

Email

Place of residence and country

Preferred language

☐ English ☐ Swedish ☐ German

Preferred format

☐ at the practice in Stockholm ☐ online ☐ not yet decided

You are coming

☐ on my own ☐ as a couple ☐ not yet decided

2. Your concern

What would you like to address in sexual therapy?

How long has this been on your mind?

Does it occur always or only in certain situations?

☐ always ☐ in certain situations ☐ it varies

How much does this weigh on you at the moment?

not at all ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 very strongly

What have you tried so far?

3. Body and health

Many illnesses, medications and life stages affect sexuality. This information helps with the assessment.

Do you have any physical illnesses or symptoms?

Do you take medication or hormones regularly? If so, which?

Are there life stages that play a role at the moment?

☐ pregnancy/birth ☐ menopause ☐ wish to have children
☐ illness/surgery ☐ none

Have physical causes already been medically assessed (e.g. gynaecological, urological)?

☐ yes ☐ no ☐ partly

4. Desire, arousal and body experience

What concerns you? (several answers possible)

☐ changed desire ☐ arousal ☐ erection
☐ lubrication ☐ orgasm ☐ pain
☐ body image ☐ sexual behaviour that feels hard to control ☐ other

Would you like to describe anything further?

5. Sexuality in the relationship

Only complete this if you are in a relationship.

How long has the relationship existed?

How would you describe your sexuality as a couple at the moment?

How do you talk with each other about wishes and boundaries?

How satisfied are you with intimacy in your relationship?

not at all ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 very

6. Sexual development

Key words are enough. We can explore this further in the session.

How were the body and sexuality talked about in your family – or not talked about?

Which messages about sexuality have shaped you?

7. Identity and relationship form

Describe yourself in the way that feels right for you. You can also leave this section open.

How do you describe your sexual orientation, your gender identity and your relationship form?

8. Boundaries and safety

Are there experiences of boundary violations or violence that should be taken into account in therapy?

☐ no ☐ yes ☐ I would rather discuss this in person

No details are needed here. If you currently feel threatened or pressured: call 112. In Sweden, Kvinnofridslinjen is available on 020-50 50 50.

9. Resources, expectations and goals

What do you experience as pleasant or strengthening in terms of closeness and sexuality?

What would you like to change through sexual therapy?

Do you have any wishes, questions or concerns about therapy?

10. Closing

Is there anything else I should know before our first session?

Date