

## Sexual History Self-Report Form

Name: \_\_\_\_\_

Date: \_\_\_\_\_

1. I became sexually active at age: \_\_\_\_\_
  2. My first sexual experience:  Consensual  Non-Consensual  Positive  Negative
  3. Currently, I am:  Not sexually active: **Go to Question #8**  Sexually active: **Go to Question #4**
  4. My sexual partner is my: \_\_\_\_\_
  5. Right now I have:  One sexual partner  More than one sexual partner
  6. Usually I have:  One sexual partner  More than one sexual partner
  7. In my lifetime, I have had sex with persons who were \_\_\_\_\_  Of the same sex only  Most often of the same sex  
 Of both sexes equally  Most often of the opposite sex  Of the opposite sex only
  8. I think about my sexual orientation as being \_\_\_\_\_ Check one of the following options:  
 Heterosexual or "Straight"  Homosexual/Gay/Lesbian  Bisexual Other: \_\_\_\_\_
  9. I would describe my comfort level with my sexual orientation (being straight, gay, bi-sexual, etc.) as,  
 Very uncomfortable  Somewhat uncomfortable  Comfortable  Very Comfortable
  10. I always practice safe sex by using condoms:  No  Yes
  11. My sexual partner or partners use birth control:  No  Yes
  12. In my lifetime, I have contracted a sexually transmitted disease  No  Yes (if yes describe): \_\_\_\_\_
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13. I have received education of HIV and AIDS:  No  Yes When \_\_\_\_\_
  14. I have been tested for HIV virus:  No  Yes When \_\_\_\_\_
  15. I would like help with the following problems:  

<input type="checkbox"/> Too much interest in sex	<input type="checkbox"/> Too little interest in sex
<input type="checkbox"/> Viewing sex on the Internet	<input type="checkbox"/> Calling for phone sex
<input type="checkbox"/> Disturbing thoughts with sexual content	<input type="checkbox"/> Difficulty with sexual performance
<input type="checkbox"/> Feeling more comfortable about my body	<input type="checkbox"/> My partner's unfaithfulness to me
<input type="checkbox"/> Feeling better about my sexual orientation	<input type="checkbox"/> Being unfaithful to my partner
<input type="checkbox"/> Sexual behaviors that leave me feeling depressed or ashamed	<input type="checkbox"/> Issues related to sexual abuse
<input type="checkbox"/> Other (describe): _____	
  16. I like my body and feel good about bringing myself pleasure when alone:  Yes  Mostly  Sometimes  No
  17. My fantasy life gets out of control and I do things I feel bad about:  Yes  No
  18. I like to look at sexual pictures on a regular basis:  Yes  No
  19. I look at sexual materials:  In Magazines  On Videos  On the Internet
  20. Please check Yes or No to the following questions:  

<input type="checkbox"/> Yes	<input type="checkbox"/> No	I have repeatedly attempted to stop certain sexual behaviors without success.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	I continue my sexual behavior despite problems it has caused.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	I desire certain kinds of sex but feel regret after acting out.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	I have lied often to conceal sexual behavior.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	I am, or I think I might be, a sex addict.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	I worry that people will find out about my sexual activities.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	I have sex and feel depressed afterwards.
  21. Do you have any other information you would like to share?  No  Yes
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