Psychotherapy Intensive Intake Form

Kimberly Keiser and Associates

Today's Date:_____

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of Birth: _____ Age: _____

Nicknames or aliases: _____ Social Security Number: _____

Home street address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home / Evening phone: _____ Email: _____

Calls or emails will be discreet, but please indicate any restrictions: _____

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? ☐ YES ☐ NO

How did this person explain how I might be of help to you? _____

_____

C. Religious and racial / ethnic identification

Current religious denomination / affiliation :

☐ PROTESTANT ☐ CATHOLIC ☐ JEWISH ☐ ISLAMIC ☐ BUDDHIST ☐ HINDU

Other (specify): _____

Involvement: ☐ NONE ☐ SOME / IRREGULAR ☐ ACTIVE

How important are spiritual concerns in your life?

_____

Which (if any) church, synagogue, temple, or meeting are you involved with?

_____

Ethnicity / national origin: _____ Race: _____ Or other similar

way you identify yourself and consider important: _____

D. Your medical care:

From whom or where do you get your medical care?

Clinic / doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ☐ YES ☐ NO

E. Your current employer

Employer: _____ Address: _____

Work phone: _____ Or other means of communication: _____

Calls will be discreet, but please indicate any restrictions: _____

F. Emergency Information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

Address: _____

Significant other / nearest friend not residing with you: _____

G. Your education and training:

Dates: _____ School: _____ Did you graduate? ☐ YES ☐ NO

Dates: _____ School: _____ Did you graduate? ☐ YES ☐ NO

Dates: _____ School: _____ Did you graduate? ☐ YES ☐ NO

Dates: _____ School: _____ Did you graduate? ☐ YES ☐ NO

H. Employment and military experiences:

Dates From	To	Name of employers	Job titles or duties	Reason for leaving

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I. Family-of-origin history:

Relative	Name	Education	Occupation	Current age (or age at death)	Illness (or age at death)	Education
Father						
Mother						
Brothers						
Sisters						
Stepparents						
Grandparents						
Uncles / Aunts						
Others						

J. Marital / relationship history?

	Spouse's name	Spouse's age at marriage	Your age at marriage	divorced / widowed
First				
Second				
Third				

K. Significant non-marital relationships

	age	name of other person	person's age when started	your age when started	Reason for ending
First					
Second					
Third					

L. Children: (Indicate those from a previous marriage or relations with "P" in the last column)

Name	Current age	Sex	School	Grade	Adjustment problems?

M: Is there any other information you think we should know?

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

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Brief Health Information Form

History

1. Starting with your childhood and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.)

Age	Illness/ diagnosis	Treatment received	Treated by	Result

2. Describe any allergies you have

To what?	Reaction you have	Allergy medications you take

3. List all medications, drugs, or other substances you take or have taken in the last year — prescribed, over-the-counter, vitamins, herbs, and others:

Medication / drug	Dose (how much?)	Taken for:	Prescribed and supervised

4. Have you done any kinds of work where you were exposed to toxic chemicals?

Date	Kinds of chemicals	Kind of work	effects

Medical caregivers

1. Your current family or personal physicians or medical agency:

Name	Specialty	Address	Phone #	Date of last visit

Other physicians treating you at present or in last five years:

Name	Specialty	Address	Phone #	Date of last visit

What kinds of physical exercise do you get?

How much coffee, cola, tea, or other sources of caffeine do you consume each day? which?

Do you try to restric your eating in any way?

Why?

Do you have any problems getting enough sleep? If yes, what problems?

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For women only

At what age did you start to menstruate (Get your period): _____

Menstrual period experiences

A. How regular are they? _____

B. How long do they last? _____

C. How much pain do you have? _____

D. How heavy are your periods? _____

E. Other experiences during periods? _____

Please list all your pregnancies:

Your age	Miscarriage	Abortion	Child born	Problems?
1.				
2.				
3.				
4.				
5.				

Menopause

If your menopause has started, at what age did it start? _____

What signs or symptoms have you had? _____

_____

Other

Do you use tobacco? ☐ YES ☐ NO

If yes, how many cigarettes / cigars / other do you use each day? _____

Have you had HIV testing in the last 6 months? ☐ YES ☐ NO

If yes, results: _____

Are there any other medical or physical problems you are concerned about?

Chemical Use Survey

In order to treat you effectively, I need information about the ways you and your family have used alcohol, drugs, and/ or other chemicals that can affect you psychologically. Please answer these questions fully.

What have you used?

1. Think about any and all chemicals you have used,and indicate how much you used (amount) and how often. Then indicate all the effects it had on you (mental, physical, family, legal, etc.).

Chemical	Age Started	Last Use	Amount and how often over the last 30 days	Effects/ consequences
Caffeine				
Tobacco (smoked)				
Tobaccao (chewed)				
Alcohol				
Marijuana / THC				
Cocaine / crack (snorted, injected, smoked)				
Inhalants / “Huffing”				
LSD, “shrooms”				
Prescribed pills				
Others: specify				

2. Write “P” above next to your primary drug of choice

3. For each chemical you currently use, what causes you to stop? Enter one or more of these letters in the last column above:

A = The money runs out.
B = I use up my supply.
C = Personal choice.
D = Unconsciousness.
E = Achieved my purpose.
F = Other reasons:

What are or were your sources of money for buying the chemicals you have used?

Which of these have you had?

☐ BLACKOUTS ☐ BAD REACTIONS ☐ WITHDRAWAL SYMPTOMS

☐ CRAVINGS ☐ OVERDOSES

☐ TOLERANCE (”Could not get high enough no matter how much I used”)

☐ PREOCCUPATION (Spent lots of time finding and using chemicals)

☐ FAILED ATTEMPTS TO CUT DOWN OR CONTROL USE

☐ DETOXIFICATION IN HOSPITAL

☐ OTHER PROBLEMS _____

Family patterns of chemical use

Please describe the chemical(s) used by family members

Member	Name	Chemical	Age Started	Last Use	Amount and how often over the last 30 days
Father					
Mother					
Brothers					
Sisters					
Spouse / Partner					
Other relatives					

Please add any other information you think is important:

Treatment for chemical use

Dates From / To	Agency Provider	Type of program	Length of treatment	Methods use	Participation in aftercare	Effects of Treatment

Self description of use

Would you say you

☐ ARE A SOCIAL DRINKER?

☐ ARE A HEAVY DRINKER?

☐ HAVE ALCOHOLISM

☐ HAVE A DRINKING PROBLEM?

Or how would you describe your use:

Would you say you

☐ ARE A RECREATIONAL DRUG USER

☐ HAVE A DRUG PROBLEM

☐ HAVE AN ADDICTION

Or how would you describe your use:

Other

Has your drinking / drug use caused you any spiritual problems?

Adult checklist of concerns

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- ☐ I have no problem or concern bringing me here
- ☐ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues (your own childhood)
- ☐ Codependence
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use—prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Headaches, other kinds of pains
- ☐ Health, illness, medical concerns, physical problems
- ☐ Housework/chores—quality, schedules, sharing duties
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Legal matters, charges, suits
- ☐ Loneliness
- ☐ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ☐ Memory problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitivity to rejection

- ☐ Pain, chronic
- ☐ Panic or anxiety attacks
- ☐ Parenting, child management, single parenthood
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems (with friends, with relatives, or at work)
- ☐ School problems (see also "Career concerns ...")
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems—too much, too little, insomnia, nightmares
- ☐ Smoking and tobacco use
- ☐ Spiritual, religious, moral, ethical issues
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness, distrust
- ☐ Suicidal thoughts
- ☐ Temper problems, self-control, low frustration tolerance
- ☐ Thought disorganization and confusion
- ☐ Threats, violence
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition
- ☐ Other concerns or issues:

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

Anxiety assessment

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

Anxiety in specific situations
- ☐ Tests
- ☐ Deadlines
- ☐ Interviews

Anxiety in personal relationships
- ☐ Spouse
- ☐ Parents
- ☐ Children
- ☐ Other

General anxiety (regardless of the situation or the people involved)
- ☐ Depression
- ☐ Powerlessness
- ☐ Poor self esteem
- ☐ Hostility
- ☐ Anger
- ☐ Irritability
- ☐ Resentment
- ☐ Phobias
- ☐ Fears
- ☐ Obsessions, unwanted thoughts
- ☐ Muscular tension
- ☐ High blood pressure
- ☐ Headaches
- ☐ Neckaches
- ☐ Backaches
- ☐ Indigestion
- ☐ Irritated bowel
- ☐ Ulcers
- ☐ Chronic constipation
- ☐ Muscle spasms
- ☐ Tics
- ☐ Tremors
- ☐ Fatigue
- ☐ Insomnia
- ☐ Sleeping difficulties
- ☐ Obesity
- ☐ Physical weakness
- ☐ Job stress
- ☐ Other

Beck Depression Inventory

This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure you do not choose more than one statement for any group, including item 16 (Changes in Sleeping Pattern) or item 18 (Changes in Appetite). ©1996 by Aaron T. Beck

1) Sadness
- 0 I do not feel sad
- 1 I feel sad much of the time
- 2 I am sad all the time
- 3 I am so sad or unhappy that I can't stand it

2) Pessimism
- 0 I am not discouraged about my future
- 1 I feel more discouraged about my future than I used to be
- 2 I do not expect things to work out for me
- 3 I feel my future is hopeless and will only get worse

3) Past failure
- 0 I do not feel like a failure
- 1 I have failed more than I should have
- 2 As I look back, I see a lot of failures
- 3 I feel I am a total failure as a person

4) Loss of pleasure
- 0 I get as much pleasure as I ever did from the things I enjoy
- 1 I don't enjoy things as much as I used to
- 2 I get very little pleasure from the things I used to enjoy
- 3 I can't get any pleasure from the things I used to enjoy

5) Guilty feelings
- 0 I don't feel particularly guilty
- 1 I feel guilty over many things
- 2 I feel guilty most of the time
- 3 I feel guilty all of the time

6) Punishment feelings
- 0 I don't feel I am being punished
- 1 I feel I may be punished
- 2 I expect to be punished
- 3 I feel I am being punished

7) Self-Dislike
- 0 I feel the same about myself as ever
- 1 I have lost confidence in myself
- 2 I am disappointed in myself
- 3 I dislike myself

8) Self-Criticalness
- 0 I don't criticize or blame myself more than usual
- 1 I am more critical of myself than I used to be
- 2 I criticize myself for all of my faults
- 3 I blame myself for everything bad that happens

9) Suicidal thoughts or wishes

0	I don't have any thoughts of killing myself
1	I have thoughts of killing myself, but I would not carry them out
2	I would like to kill myself
3	I would kill myself if I had the chance

10) Crying

0	I don't cry anymore than I used to
1	I cry more than I used to
2	I cry over every little thing
3	I feel like crying, but I can't

11) Agitation

0	I am no more restless or wound up than usual
1	I feel more restless or wound up than usual
2	I am so restless or agitated that it's hard to stay still
3	I am so restless or agitated that I have to keep moving or doing something

12) Loss of interest

0	I have not lost interest in other people or activities
1	I am less interested in other people or things than before
2	I have lost most of my interest in other people or things
3	It's hard to get interested in anything

13) Indecisiveness

0	I make decisions about as well as ever
1	I find it more difficult to make decisions than usual
2	I have much greater difficulty in making decisions than I used to
3	I have trouble making any decisions

14) Worthlessness

0	I do not feel I am worthless
1	I don't consider myself as worthwhile and useful as I used to
2	I feel more worthle as compared to other people
3	I feel utterly worthless

15) Loss of Energy

0	I have as much energy as ever
1	I have less energy than i used to have
2	I don't have enough energy to do very much
3	I don't have enough energy to do anything

16) Changes in sleeping pattern

0	I have not noticed any change in my sleeping pattern
1a	I sleep somewhat more than usual
1b	I sleep somewhat less than usual
2a	I sleep a lot more than usual
2b	I sleep a lot less than usual
3a	I sleep most of the day
3b	I wak eup 1–2 hours early and can't get back to sleep

17) Irritability

0	I am no more irritable than usual
1	I am more irritable than usual
2	I am much more irritable than usual
3	I am irritable all the time

18) Changes in appetite

0	I have not experienced any change in appetite
1a	My appetite is somewhat less than usual
1b	My appetite is somewhat greater than usual
2a	My appetite is much less than before
2b	My appetite is much greater than usual
3a	I have no appetite at all
3b	I crave food all the time

19) Concentration difficulty

0	I can concentrate as well as ever
1	I can't concentrate as well as usual
2	It's hard for to keep my mind on anything for very long
3	I find I can't concentrate on anything

20) Tiredness or fatigue

0	I am no more tired or fatigued than usual
1	I get more tired or fatigued more easily than usual
2	I am too tired or fatigued to do a lot of the things I used to do
3	I am too tired or fatigued to do most of the things I used to do

21) Loss of interest in sex

0	I have not noticed any recent changes in my interest in sex
1	I am less interested in sex than I used to be
2	I am much less interested in sex now
3	I have lost interest in sex completely

After you have completed the questionnaire, add up the score for each of the 21 questions.
The following table indicates the relationship between total score and level of depression according to the Beck Depression Inventory.

Classification	Total Score	Level of Depression
Low	1–10	Normal ups and downs
	11–16	Mild mood disturbance
Moderate	17–20	Borderline clinical depression
	21–30	Moderate depression
Significant	31–40	Severe depression
	Over 40	Extreme depression

Sexual Assessment Screen

Nature of Problem

1) Who initiated therapy? [Who has problem?]

2) What prompted you to come at this time for therapy?

3) Describe the nature of the current problem(s).

5) How have you (or the two of you) attempted to handle the problem to date?

6) What is your understanding of how this problem was created?

7) What specifically would you (each of you) like to see as an outcome of coming to therapy? [Same goals for couple?]

Consequences and Adaptive Function

8) If therapy is successful, what will you be able to do that you are unable to do now?

9) How will this change anything in your current life, relationship, personality, or partner's personality?

10) How does the problem affect you or your partner's sexual functioning?

11) What significance does the problem have with respect to your own sexual functioning?

Antecedent Events and Stimuli

12) When did the problem first occur? What was occurring in your life at that time concurrent events?

13) (If there is more than one problem, or both partners have a problem): Which problem do you recall as having developed first?

14) Under what circumstances does the problem occur? What circumstances intensify the problem(s)?

15) Under what circumstances have they functioned/worked? (People, situations, circumstances, locations, time of the day, thoughts, images, feelings, and sensations).

16) Where and when does the problem temporarily get better or improve?

Individual Interview Questions

1) What was your major source of sex education?

2) Was affection freely shown by your parents to one another?

3) What were your parent's attitudes towards sex?

4) As a child, did you ever see anyone engaging in sexual activity? Were you ever caught or punished for sexual activity?

5) In what ways has your religion and family background influenced your attitudes toward sex? Growing up, were you allowed to ask questions?

6) How old were you when you began petting? How many partners did you share petting with before you graduated high school? Between high school and marriage? What kinds of petting did you engage in? How would your parents respond if they had known?

7) How old were you when you first masturbated? How did you learn about masturbation? How did you feel about masturbation? With what frequency did you masturbate in your teens? What was the maximum frequency? What techniques have you used for masturbating?

8) Do you practice safe sex? What do you mean by your response? Do you wonder if you have a sexual disease?

9) How attractive do you feel at this point in your life? During courtship?

10) How old were you when you first engaged in intercourse, and age of partner?

11) Location and circumstances of the first intercourse? Were there any problems or difficulties? How did you feel? Were you orgasmic?

12) Premarital sexual experiences: Any problems with erection, prematurity, or delayed ejaculation? Number of premarital sexual partners, frequency of intercourse with spouse before marriage. Source of restraint for not engaging in premarital sex. Negative experiences?

13) How was your sexual experiences in previous relationships (compared to current)?

14) Have you ever had any extramarital (outside of relationship) or group sex experiences?

15) What attracts, excites and stimulates you sexually? Describe the situation you find most desirable and stimulating for lovemaking.

16) Any history of unwanted sexual activity (such as incest, assault, or rape), abortions, out-of-wedlock pregnancies, or prostitution?

17) Do you have any sexual thoughts of others who are the same sex as you? Have you ever had homosexual involvements (or heterosexual involvements); different/unusual sexual acts which you participated in or desired?

18) How do you express non-sexual affections with others (same and different sex)?

19) Preferences and Ideals: What would you like from an ideal sexual partner, or ideally from your current partner? What would you be willing to give to such a partner?

20) How would you describe yourself? How would you describe your partner?

21) Do you tell him/her what pleases you most sexually? Displeases you?

22) What do you want most in the way of attitude, behavior, etc. from your partner that he/she does not provide you now?

23) What attitude or behavior do you receive from your partner that you value the most?

24) What trait, behavior pattern, or habit does your partner have which tends to diminish your sexual feeling or desire for him/her?

25) What trait (behavior) diminishes your feeling for him/her in non-sexual situations?

26) What attracts, excites and stimulates your partner sexually?

27) How do you feel about your genitals, and about touching and observing your partner's genitals?

28) Fantasy: How often do you fantasize during intercourse and while masturbating? Are they erotically stimulating? Are you comfortable with the content of your fantasies?

29) Are you concerned about how your partner has or will react to what stimulates/excites you?

30) Do you engage in any sexual activity that causes harm to yourself or others? Do you engage in any activity which you would not want others to know about? Do you worry about how sex is a part of your life?

Conjoint Interview Questions

1) How did the two of you meet?

2) Where either of you in another relationship at that time?

3) How would you describe or summarize your relationship?

4) What interests do you share and enjoy together? Independently?

5) How much time do the two of you spend together? Are you or your partner satisfied with the amount of time spent together?

6) What issues/problems do you two have that are areas of conflict (number and frequency or conflicts)?

7) What is the communication like between you? Do you confide in one another? Does either one of you use or say words which are particularly painful?

8) Has having children impacted the relationship?

9) What is the frequency of sexual activity/intercourse recently; during first year? Did you enjoy this frequency level? What contributed to maintaining the same level or changing the frequency?

10) What time does sexual activity usually takes place, and who usually chooses the time? Are there any privacy, noise issues, or intrusions?

11) What is the level of verbal expressiveness during sexual activity (freedom and openness)?

12) When did you last have sexual relations together?

Who initiated?
How were cues given and interpreted?
What percentage of the time does each usually initiate?
What occurred in foreplay, and length of foreplay?
Desire more or less?
Level of arousal (0-10).
Lubricated?
Use of artificial lubrication and feeling about it.
What kinds of stimulation do you prefer?
Do you ask for this?
Do you ever experience any physical discomfort during lovemaking?

[Does sex serve a function in the marital system?
(to gain advantage or control elsewhere in the relationship; used for trade-offs elsewhere?).

What are the relational issues involved:
1) independence, activity, power, control and domination versus dependence, passivity, and submission.
2) closeness versus distance; trust versus distrust.
3) competition versus cooperation.
4) perceptual stereotypes of men, women, and the self.
5) problem-solving styles and the approach to handling differentness
(communication and emotional expressiveness—underexpressiveness).]

Male Interview Questions

[Any history of surgery or illness (VD, diabetes, arteriosclerosis, hypertension liver or kidney failure, Parkinson's disease, surgery in the pelvic area, spinal cord injuries, Peyronie's disease or priapism)?]

Assessment of Sexual Self-schema

1) Are you satisfied with your feelings about sex?

2) Do you derive pleasure from sex?

3) Do you feel that you are a good sexual partner. How about your knowledge and skill competence?

4) Have you ever had sex when you really didn't feel like it?

5) Are you using any method of birth control?

6) Have you even had any medical procedures performed on your sexual/reproductive organs?

7) Do you experience any urinary problems?

Feelings about body image

8) If you could change anything about your body what would it be? Why?

9) Have you ever had any cosmetic treatment? What was the reason for this treatment?

10) Do you think that it is important to have an erection, ejaculation, or orgasm for sexual satisfaction, for yourself or your partner?

11) How would you describe your penis (length, girth, shape, color, size, curvature, circumcision)?

12) Do you feel that your genitals are attractive?

Female Interview Questions

Assessment of Sexual Self-schema

1) Are you satisfied with your feelings about sex?

2) Do you derive pleasure from sex?

3) Do you feel that you are a good sexual partner? How about your knowledge and skill competence?

4) Have you ever had sex when you really didn't feel like it?

5) Are you pregnant now or are you afraid of getting pregnant?

6) Are you currently using birth control? What method?

7) Have you have any unwanted or unexpected pregnancies? Miscarriages? Difficulties getting pregnant? How old were you? What happened?

8) How are your menstrual cycles (peri-menopausal/menopausal)?

9) Have you even had any medical procedures performed on your sexual/reproductive organs (ovaries, tubes, uterus, vagina, vulva)?

Feelings about body image

10) If you could change anything about your body what would it be? Why?

11) Have you ever had any cosmetic treatment? What was the reason for this treatment?

12) Do you think that it is important to have an erection, ejaculation, or orgasm for sexual satisfaction, for yourself or your partner?

13) How would you describe your genitals?

14) How familiar are you with your genitals (vulva, vagina, clitoris)?

15) Do you feel your genitals are attractive?

16) Are you satisfied with your vaginal muscle control, tightness, length?

17) Do you exercise your genital (pubococcygeal) muscles using Kegel squeezes? Does this impact either your satisfaction or your partner's satisfaction?

18) Do you experience any urinary problems?

19) Vaginal infections? frequency, duration, recurring? Douche? Spray?

20) At what age do you remember first menstruating, breast development, pubic hair (age at puberty)?

21) Menstrual difficulties: dysmenorrhea or amenorrhea? Discharge from nipples of your breast? Hair loss? Hirsutism? Undescended testes? Gynecomastia? Infertility?

22) Any problem reactions to vaginal odors and secretions, body odor, genital odor (self or other)?