

The Center for Health & Healing of Seal Beach  
 13001 Seal Beach Blvd. suite 360  
 Seal Beach, CA 90740



Holly Richmond, Ph.D.  
 Certified Sex Therapist  
 Your Body. Your Mind. Your Health.



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**CONFIDENTIAL SEXUAL HISTORY**

Name:	Date:
Address:	Phone:
Email:	DOB:
Relationship Status:	OK to Mail?      Ok to Call?

**Gender Identification:** F · M · Other:

**Present sexual identity:** Heterosexual · Homosexual · Bisexual · Transvestite · Cross Dresser · Transsexual · Other:

**Living situation:** Alone · With spouse · With a partner · With friends · With a roommate · With parents · Other:

Age of first sexual feeling		Age of first erotic dream	
Age of first masturbation		Age of first sexual attraction	
Age of first Date		Age of first sexual intercourse	
Age of first orgasm		Age of first Menstruation if applicable	
Date of Last Orgasm		Date of Last Sexual Activity (Inc. solo)	

Age of Menopause		* Type of hormone supplement used: (RX or natural/OTC)	
		How long hormone supplement used?	

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**PLEASE WRITE BRIEF ANSWERS TO THE FOLLOWING QUESTIONS:**

1. What childhood messages about sex/sexuality did you receive? Of those, how might they affect your sexuality today?
  
  
  
  
  
  
  
  
  
  
2. What are any concerns you may have about your sexuality? For example: If you are female, this may include concerns regarding periods or pregnancy, or if male this may include erectile issues, etc.
  
  
  
  
  
  
  
  
  
  
3. What are any concerns you may have about being pre-/ peri-/ post-menopausal?
  
  
  
  
  
  
  
  
  
  
4. What have been your experiences with achieving orgasm? Alone? With a partner?
  
  
  
  
  
  
  
  
  
  
5. What have been your experiences with self-pleasuring or masturbating yourself?
  
  
  
  
  
  
  
  
  
  
6. What is your present pattern and frequency for self-pleasuring/ masturbation?
  
  
  
  
  
  
  
  
  
  
7. How did and how do you feel about your body (as a child, growing up, as a young adult and now)?



8. Describe the history of your sexual relationships: (Take extra paper or use other side if you need to; talk about the number of partners, what sexual activities you have experienced, and the issues and conflicts that have emerged for you in intimate relationships.)
  
9. Describe any feelings you may have about having sexual contact with your present or possible sexual partner(s):
  
10. Describe your present sexual interactions, such as intercourse or masturbation, turn-on's, your present pattern for sexual pleasure, how often, your current number of partners, etc.:
  
11. How often do you think about or desire to have sex?  
 Once per day · More than 4 times per day · Once per week · More than 4 times per week · Less than 4 times per month ·
  
12. Check below those of which are sexual 'turn-on's' for you:

Erotic or pornographic magazines		Erotic or pornographic videos	
Fantasy during masturbation		Phone sex lines (900#'s)	
Massage parlors		Online sex chats	
Internet sex (live)		Other online sex with others	
Prostitutes		S & M play	
Cross dressing		Swinging clubs	
Exotic dance clubs		Voyeurism	
Erotic books		Romance novels	
Dirty talk		Other	

13. Are you interested in being trained in bodywork, such as masturbation or other sexual enhancement techniques?

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14. Do you want to work with a sex surrogate ?
  
15. Are you currently seeing a psychotherapist or body worker?
  
16. Do you want a referral to a psychotherapist or body worker?
  
17. Do you have any pre-existing medical conditions that may affect your sexuality? (For example, diabetes, hypertension, heart disease...) If so please describe:
  
18. Are you currently taking any prescribed medications, such as for hypertension, diabetes, depression, anxiety or cardiovascular disease? If so please describe:
  
19. Do you drink more than moderately or use recreational drugs?
  
20. Are you interested in using safe, natural products that can enhance your sexual experience?
  
21. What are your long-term sexual goals?
  
22. What is your primary goal for our work together?
  
23. Are you willing to commit to your sexual success, and do you agree to complete assignments and allow yourself your sexual pleasure? YES NO
  
24. Please write here anything else related to your past or present experiences. Include anything that may be important for me to know, so that I may assist you toward reaching your sexual goals:

I hereby release Dr. Holly Richmond and or her associates for any damages that may result from sexual treatment:

Patient:

Date:

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ADDITIONAL NOTES: