

Sexual

Circle all that apply: Thinking about having sex for the first time Having sex now Not having sex now

Yes No

- Pain, discomfort, or bleeding with intercourse
- Recent vaginal infection _____
- Vaginal itching
- Vaginal burning
- Foul odor
- Unusual discharge
- Treated for an STD in past year _____
- Did you have sex because you wanted to get it over

Yes No

- New sexual partner in the last year
- More than one sexual partner in the last year
- Experienced physical abuse (being hit, kicked, slapped)
- Experienced emotional abuse (threatened/made to feel worthless)
- Forced into sex by family member or partner
- Utilize protection from STDs/HIV _____
- Treated for pelvic inflammatory infection in past year

How old were you when you first had intercourse? _____

When you were young did someone ever put something in your vagina? Yes No

Were/Are your sexual partners: men women both IV drug users partner with multiple partners or at risk for HIV/STD

What types of sex have you had? Oral Anal Vaginal None

Contraceptives

Check all of the birth control methods you have used:

- Abstinence (not having sex) Pill Sterilization Foam, suppository, gel, film
- Withdrawal Condoms Diaphragm Depo Provera
- Norplant / Implanon IUD Sponge Birth Control Patch
- Vaginal ring Natural Family Planning Other _____

What is the most recent birth control method you have used? _____

Are you using this method now? Yes how long? _____ No If no, when did you stop using it? _____

If taking pills are you taking the regularly? Yes No

Have you had problems with any birth control methods? Yes No;

Does your current method cause the following side effects:

- Swelling Nausea Numbness/tingling in arms or legs Other _____

Describe _____

Client signature and date _____

Client signature and date _____

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Counseling

Topic	Addressed	NA
Health Promotion		
Tobacco cessation		
Drug/Alcohol Use		
STD/HIV risk reduction		
Overview/Review of Method (s)		
Adolescents Only		
Abstinence		
Resisting Sexual Coercion		
Family Participation		
Report of Abuse or Neglect		

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Tobacco Cessation		
Drug/Alcohol Use		
STD/HIV risk reduction		
Overview/Review of Method		
Adolescents Only		
Abstinence		
Resisting Sexual Coercion		
Family Participation		
Report of Abuse or Neglect		

*√ individual boxes when topic Addressed or √ NA when Not Applicable

Scheduled for exam on _____

Method Given _____

Reviewed by _____ Date _____

Scheduled for exam on _____

Method Given _____

Reviewed by _____ Date _____

Client Name _____ Age _____ DOB ____/____/____