Psychosexual Evaluation

Name: ______________________ Date of Birth: ______________ dd / mm / yyyy

Date of Evaluation: ______________ dd / mm / yyyy Referring Clinician: ______________________

Reason for Evaluation:

Medical History:

Psychiatric History:

Previous Therapy/Treatment:

Current Medications:

Age at Sexual Maturity: ______________________

First Sexual Experience:

Current Sexual Practices:

Sexual Orientation and Identity:

Significant Past Relationships:

Current Relationship Status:

Primary Sexual Concerns:

Duration of the Problem:

Perceived Cause(s) of the Problem:

Impact on Relationship(s):

Client's Attitude Towards the Evaluation:

Emotional State During Interview:

Level of Insight into Sexual Behavior:

Cooperation with Evaluation Process:

Sexual Desire Inventory:

Sexual Functioning Questionnaire:

Risk Assessment for Sexual Offense (if applicable):

Other (specify):

Attitudes Toward Sexuality:

Understanding of Consent:

Use of Pornography:

Paraphilic Interests or Behaviors:

History of Sexual Abuse or Trauma:

Consistency in Sexual Interests:

Mental Health Status:

Substance Use/Abuse:

Social Supports:

Risk of Harm to Self/Others:

Risk of Recidivism (if applicable):

Protective Factors:

DSM-5 Diagnoses: ______________________ Sexual Dysfunction(s): ______________________

Paraphilic Disorder(s): ______________________

Therapeutic Interventions:

Referral to Specialists (if needed):

Follow-Up and Monitoring:

Client Education:

Evaluator's Comments:

Prognosis:

Signature of Evaluator:
Date: ______________________ dd / mm / yyyy

Client's Signature:
Date: ______________________ dd / mm / yyyy