OPIsI: Initial Screen

It is normal to have questions about how your condition or life stage may impact sexuality and intimacy. Many individuals would like more information regarding this topic, but do not know who to ask or what to ask. Occupational therapy practitioners work with individuals of all ages to improve their ability to perform activities of daily living. Sex and intimacy are considered activities of daily living. Although you may be apprehensive to discuss the topic or complete the questionnaire, your occupational therapy practitioner can use the following information to help you in this area or make a referral for specialized services if needed. Please be aware that you are not obligated to complete this form, any information you provide or discuss voluntarily with the occupational therapy practitioner will be strictly confidential. Please return this form to your occupational therapy practitioner if any of the items below apply to you.

Please read each statement and select the items that apply to you.	**Check all that apply**
Sexuality and intimacy are important aspects of my life	
I have concerns about the overall impact my condition or life stage has on:	
Sexual Activity: My ability to safely engage in sexual and/or intimate activities (alone or with another person). Sexual activities may include hugging, kissing, foreplay, masturbation, oral sex, anal sex, vaginal sex, and the use of sexual toys or devices	
Sexual Interest: My desire, libido, motivation, or drive to participate in sexual activities (alone or with another person)	
Sexual Response: My body's physical sexual response associated with sexual activity including physiological arousal, response to erogenous zones, nipple erection, clitoral excitation, erection, vaginal lubrication, prostate release, ejaculation, and/or orgasm	
Sexual Expression: My ability to express myself as a sexual being. Sexual expression includes expressing sexuality and/or gender identity through behaviors, mannerisms, preferences, appearance, pronouns, political engagement, acquired tendencies, daily routines, symbolic actions, or preferred roles	
Sexual Self-View: How I see myself as a sexual being, including my sexual identity, gender identity, sexual self-esteem, or body image (examples: given my condition, I no longer feel very masculine/feminine/other, I lack confidence in my ability to be a partner, or I worry that no one will find me attractive)	
Intimacy: My ability to give and receive affection needed to successfully interact in my role as intimate partner	
Sexual Health: My ability to practice safe sex	
Family Planning: My ability to manage aspects of fertility, pregnancy, or parenthood	
Based on my identified concerns:	
I am interested in receiving handouts, brochures, or online resources from an occupational therapy practitioner about this topic	
I would like to receive specific suggestions from an occupational therapy practitioner to increase my ability to participate and/or improve my performance in these areas	
I would like my partner to be included when addressing this topic as part of my occupational therapy	
I would be interested in connecting with individuals with similar conditions (either one-on-one, online, or in a support group setting) to discuss challenges, personal experiences, coping strategies, and success stories related to sexuality and intimacy	
Additional Comments or Concerns:	