****

**Butterfly Hug Therapy**

**Kimberly Burke, LICSW** *WA License LW60682845*

*18978 front street ne - Poulsbo WA 98370 - 253***.***372.2412*

Parent Questionnaire Date Completed: \_\_\_\_\_\_\_\_\_\_\_

**Dear Parents:** Please complete the following questionnaire so that we may have accurate background information regarding your child. All information will be kept confidential and will not be released without your permission.

Name of child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ Questionnaire completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Concerns:** What are the concerns you would like help with?

What made you seek help at this time?

What do you want to see happen in therapy?

**Previous Interventions:** What home and/or school interventions have you tried:

 If your child has previously seen a therapist, please provide therapist’s name, reason, dates:

**Family Constellation:** With whom does the child live? (Include siblings and their ages, and any relatives/non-relatives in the home)

If parents are separated or divorced, date of separation or divorce: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Include a copy of the parenting plan.)

**Family Psychiatric History:** Has anyone in your family been diagnosed with or treated for: (*if YES please indicate which relative - mother, father, etc.)*

Bipolar [ ] no [ ] yes \_\_\_\_\_\_\_\_ Schizophrenia [ ] no [ ] yes \_\_\_\_\_\_\_\_

Depression [ ] no [ ] yes \_\_\_\_\_\_\_\_ Post-traumatic stress [ ] no [ ] yes \_\_\_\_\_\_\_\_

Anxiety [ ] no [ ] yes \_\_\_\_\_\_\_\_ Alcohol Abuse [ ] no [ ] yes \_\_\_\_\_\_\_\_

Anger/Violence [ ] no [ ] yes \_\_\_\_\_\_\_\_ Other Substance Abuse[ ] no [ ] yes \_\_\_\_\_\_\_\_

Suicide [ ] no [ ] yes \_\_\_\_\_\_\_\_ Learning Disabilities [ ] no [ ] yes \_\_\_\_\_\_\_\_

ADHD [ ] no [ ] yes \_\_\_\_\_\_\_\_ Autism [ ] no [ ] yes \_\_\_\_\_\_\_\_

**School:** What school does your child attend?

What is your child’s current grade?

What is their experience with school?

What does the teacher say about your child?

**Medical/Developmental:**Pregnancy or birth complications: \_\_\_\_\_\_\_yes \_\_\_\_\_\_\_\_ no. If yes, please explain:

Developmental milestones: (ages) Sitting: \_\_\_\_\_\_\_Walking: \_\_\_\_\_\_\_Talking: \_\_\_\_\_\_ Toileting: \_\_\_\_\_\_

Please describe any current or past medical issues (illnesses, allergies, surgeries, injuries, congenital conditions, etc.):

Name of current physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Clinic\_\_\_\_\_\_\_\_ Date of last physical exam: \_\_\_\_\_\_\_\_\_\_

What medications and/or supplements is your child currently taking?

Medication Dosage Reason Prescriber

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle all that your child experiences:**

|  |  |  |
| --- | --- | --- |
| Learning disabilities/Special Ed/IEP/504 | Depressed mood | Not paying attention |
| Speech difficulties | Self-harm | Impulsivity |
| Hearing difficulties | Suicidal thoughts or attempts | Difficulty concentrating |
| Suspected or actual giftedness | Sleeping too much or too little | Excessive energy |
| Defiance | Change in appetite | Loses necessary things |
| Verbal aggression | Crying spells | Social difficulties |
| Physical aggression | Excessive guilt | Anxiety attacks |
| Difficulty calming down | Hopelessness | Fears |
| Rigidity | Isolation | Doesn’t listen |
| “Meltdowns” | Irritability | Careless mistakes |
| Criminal activity | Extreme mood swings | Doesn’t complete tasks |
| Alcohol/drug/nicotine use | Drop in grades | Forgetful |
| “Shy” | Afraid to try new things | Excessive worry |
| Argues with adults | Blames others | Difficulty organizing tasks |
| Self-conscious | Blames self | Gender questioning |
| Bullies others | Avoids difficult tasks | Often angry |

**What are your child’s hobbies and interest?**

How much screen time (phone, TV, movies, computer, video games) on average does your child have a day?

**Anything else you would like your therapist to know:**