**A drawing of a banana

Description automatically generated with medium confidence**

**Butterfly Hug Therapy**

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

*18978 Front street NE - Poulsbo WA 98370 - 253***.***372.2412*

Adult Questionnaire Date Completed: \_\_\_\_\_\_\_\_\_\_\_

Please complete the following questionnaire, providing accurate background information. All information will be kept confidential and will not be released without your permission.

Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Concerns:** With what concerns would you like help?

What made you seek help at this time?

What do you want to see happen in therapy?

**Previous Interventions:** What interventions have you tried, including previous therapy, coping skills (healthy and unhealthy), meds, etc.:

Have you ever been hospitalized for psychiatric reasons?

What medications and/or supplements are you currently taking?

Medication Dosage Reason Prescriber

**Symptoms:** Please circleany symptoms you are experiencing

|  |  |  |
| --- | --- | --- |
| Feeling like you don’t need to sleep  Difficulty falling asleep  Difficulty staying asleep  Difficulty getting out of bed  Not feeling rested in the morning  Fatigue  Increased energy  Decreased energy  Changes in eating/appetite  Use of laxatives/Voluntarily vomiting Binge eating  Weight gain/loss  Excessive exercise  Thoughts about harming/killing yourself  Thoughts about harming/killing someone else  Self-harm/cutting  Increased muscle tension  Seeing things other people don’t see  Hearing voices when no one else is present  Physical sensations others don’t have  Feeling that your thoughts are controlled or placed in your mind  Feeling that the television or radio is communicating with you  Crying spells  Difficulty calming down  Drop in grades/work performance  “Meltdowns” | Lack of motivation  Change in libido  Persistent loss of interest in previously enjoyed activities  Withdrawing/isolating  Frequent feelings of guilt  Hopelessness Helplessness  Worthlessness  Sadness  Irritability  Depressed mood  Outbursts of anger Decreased ability to handle stress  Abusive Relationship  Concerns about your sexuality or gender  Verbal/physical aggression  Defiance  Criminal activity  Flashbacks  Nightmares  Large gaps in memory  Easily startled, feeling jumpy  Feeling as if you were outside yourself, detached, observing what you are doing  Puzzled as to what is real and unreal  Persistent, repetitive, intrusive thoughts, impulses, or images | Anxiety  Worry that is frequent/difficult to control  Panic attacks  Avoiding people, places, activities or things  Difficulty leaving your home  Fear of certain objects or situations  Repetitive behaviors or mental acts (i.e. counting, checking, washing)  Feeling or acting unlike yourself  Feeling numb  Difficulty expressing emotions  Rapid mood changes  Engaging in risky behavior  Racing thoughts  Beginning many projects  Difficulty concentrating or thinking  Not paying attention  Losing or forgetting things  Impulsivity  Rigidity |
|  |  |  |

**Circle which substances you currently use or have used in the past:**

|  |  |  |
| --- | --- | --- |
| Caffeinated beverages | Alcohol | Ecstasy/Molly |
| Tobacco | Meth/amphetamine | Inhalants |
| Nicotine vape | Opioids | Ketamine |
| Chewing tobacco | Mushrooms | Prescription drugs (for fun) |
| Marijuana  Crack | LSD  PCP | Heroin |
| Cocaine | Acid | Other: |

**Family history:** Who raised you?

Describe your relationship with your parents/guardians currently and in the past.

List your siblings and the quality of your relationship now:

List several words that describe your childhood:

Are you: [ ] single [ ] in a relationship [ ] divorced [ ] married [ ] cohabitating [ ] other \_\_\_\_\_\_\_

List everyone who currently lives with you, their relationship to you, and the quality of the relationship:

List other supports you have (i.e. friends, clubs, sports, church, community group, etc.):

**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 \_\_\_\_\_\_\_\_

**Developmental/Medical:**

As a baby, did you meet your developmental milestones (sitting, walking, talking, toileting) [ ] Earlier than average [ ] Average [ ] Later than average

How do people who knew you when you were little describe you as a child?

List previous and current speech, vision, or hearing problems or other disabilities:

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

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

**Trauma History:** (Trauma is any event that overwhelms your ability to cope.)

Have you ever been in a situation in which you felt like you or someone else was about to die? [ ] Yes [ ] No

Have you witnessed or experienced physical or verbal abuse in your family? [ ] Yes [ ] No

Have you ever been homeless or not had enough food or clothing? [ ] Yes [ ] No

Have you ever witnessed or experienced bullying/harassment? [ ] Yes [ ] No

Have you witnessed or experienced sexual assault or rape? [ ] Yes [ ] No

Have you witnessed or experienced terrible accidents? [ ] Yes [ ] No

Have you ever made a suicide attempt? [ ] Yes [ ] No

When was the last time you had a suicidal thought?

Do you have access to guns?

**Education and Employment History:**

What is the last grade in school you completed?

What is/was school like for you?

Do you have suspected or diagnosed learning disabilities, ADHD, autism?

Have you ever had Special Education, an IEP, or a 504?

If you are currently employed, what is your job?

Do you enjoy your work?

Is your job stable?

Do the problems for which you are seeking help affect your school or work?

If you have served in the military, what branch?

**Legal History:** If you have ever been arrested, what were the charges?

If you have current legal problems, what are they?

**List your hobbies, interests, and strengths:**

How much screen time (phone, TV, movies, computer, video games) on average do you have a day?

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