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**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 sleepDifficulty falling asleepDifficulty staying asleepDifficulty getting out of bedNot feeling rested in the morningFatigueIncreased energyDecreased energyChanges in eating/appetiteUse of laxatives/Voluntarily vomitingBinge eatingWeight gain/lossExcessive exerciseThoughts about harming/killing yourselfThoughts about harming/killing someone elseSelf-harm/cuttingIncreased muscle tensionSeeing things other people don’t seeHearing voices when no one else is presentPhysical sensations others don’t haveFeeling that your thoughts are controlled or placed in your mindFeeling that the television or radio is communicating with youCrying spellsDifficulty calming downDrop in grades/work performance“Meltdowns” | Lack of motivationChange in libidoPersistent loss of interest in previously enjoyed activitiesWithdrawing/isolatingFrequent feelings of guilt HopelessnessHelplessnessWorthlessnessSadness IrritabilityDepressed moodOutbursts of angerDecreased ability to handle stressAbusive RelationshipConcerns about your sexuality or genderVerbal/physical aggressionDefiance Criminal activityFlashbacksNightmaresLarge gaps in memoryEasily startled, feeling jumpyFeeling as if you were outside yourself, detached, observing what you are doingPuzzled as to what is real and unrealPersistent, repetitive, intrusive thoughts, impulses, or images | AnxietyWorry that is frequent/difficult to controlPanic attacksAvoiding people, places, activities or thingsDifficulty leaving your homeFear of certain objects or situationsRepetitive behaviors or mental acts (i.e. counting, checking, washing)Feeling or acting unlike yourselfFeeling numbDifficulty expressing emotionsRapid mood changesEngaging in risky behaviorRacing thoughtsBeginning many projectsDifficulty concentrating or thinkingNot paying attentionLosing or forgetting thingsImpulsivityRigidity |
|  |  |  |

**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) |
| MarijuanaCrack | LSDPCP | 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:**