

**Debbi J. Dunbar, MS, LPC**

RIDGLEA BANK BUILDING

6300 Ridglea Place | Suite 212 | Fort Worth, TX 76116 | 817.739.2421

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***PERSONAL INFORMATION***

Please complete information as fully and accurately as you can. This information informs and guides the counseling process. Please ask for help, if needed. If information does not apply, please draw a line through it. If you become distressed while completing this form, please stop, and bring the document with you to the first session, we can complete it together. This information is strictly confidential.

Name \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI

Primary Phone: \_\_\_\_\_ (Cell/Home | May Call: yes/no | Message: yes/no)

Secondary Phone: \_\_\_\_\_ (Cell/Home | May Call: yes/no | Message: yes/no)

Email: \_\_\_\_\_ (Work/Home | May Email: yes/no)

Home Address: \_\_\_\_\_  
Street Apt. City State Zip

Marital Status: \_\_\_\_\_ How Long? \_\_\_\_\_

Occupation: \_\_\_\_\_ How Long? \_\_\_\_\_

Gender: Male\_\_ Female\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_  
Name Relationship Phone

Are you currently in counseling elsewhere? No\_\_ Yes\_\_

If yes, are you looking for adjunct EMDR Therapy? Please list the name and contact information for your therapist

\_\_\_\_\_

How did you hear about Debbi J. Dunbar, LPC? \_\_\_\_\_

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### COUNSELING GOALS

Please list up to 4 specific areas of concern that bring you to counseling along with symptoms. When did concerns begin (note age or timeframe)? How frequently are you affected (0-rarely ... 7-daily)? Please rate upset level when affected (0-minimal ... 10-highly distressing)?

1)

2)

3)

4)

How have you addressed the areas of concern listed above? Please note if efforts are helpful (H), unhelpful (U), or incomplete (I):

What, if any, cost has been associated with your attempts? In the form of time, money, energy, relationships, pain, etc...

What prompts you to seek counseling now?

What would you like to gain from your counseling experience?

How will you know when your counseling goals are attained?

What qualities do you look for in a therapist?

How long do you anticipate counseling to last?

How motivated are you to address and reduce the symptoms you listed above?

Low 1 2 3 4 5 6 7 8 9 10 Hig



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**TREATMENT HISTORY**

**\*\* If you have seen a mental health professional (psychiatrist, psychologist, or counselor) \*\***

What did you like? \_\_\_\_\_

What did you dislike? \_\_\_\_\_

Mental Health Professional \_\_\_\_\_

Name

City/State

Phone #

Dates of Service \_\_\_\_\_

What other therapeutic treatments have you sought for the concerns listed on page 2? How were treatments helpful?

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

How were treatments NOT helpful? \_\_\_\_\_

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

What would you say you learned from your former therapeutic experience(s)? \_\_\_\_\_

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

How would you like the experience to differ this time? \_\_\_\_\_

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

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## GENOGRAM

Family of Origin is the family you were born into or the family that raised you. Knowing the history and relationships within your family can be helpful during our work together. Please use the next page to draw your family genogram. This page is a general guide to help you create your genogram.



= Male



= Female

Please identify significant relationships (or absence of significant relationships) with family members may include significant aunts, uncles, and cousins. Please include current family (spouse and children) if applicable.

Below are instructions to help draw your genogram:

- Draw straight line to indicate marriage
- Draw a slash through that line to indicate divorce
  - If divorced - indicate how old you were when your parents divorced
    - how were you affected?
    - what were the living arrangements after the divorce?
  - If parents remarried - indicate how old you were when that happened
    - describe your connection/closeness with your step-parent(s)?
- Draw a slanted line through the shape to indicate deceased family members, note how close you were to that person, how old you were when they passed and who helped you through the experience.
- Make a note next to any family member that has a mental illness (i.e. depression, anxiety, or bipolar), an addiction or if they experienced neglect/abuse.
- Make a note next to significant family members that indicate your relationship with that person.
  - C = Close relationship
  - S = Supportive Relationship
  - N = Neutral Relationship – neither close nor distant
  - D = Distant relationship
  - B = Broken, non-existing relationship
  - A = Addiction – please note the type
  - MI = Mental Illness – please note the diagnosis

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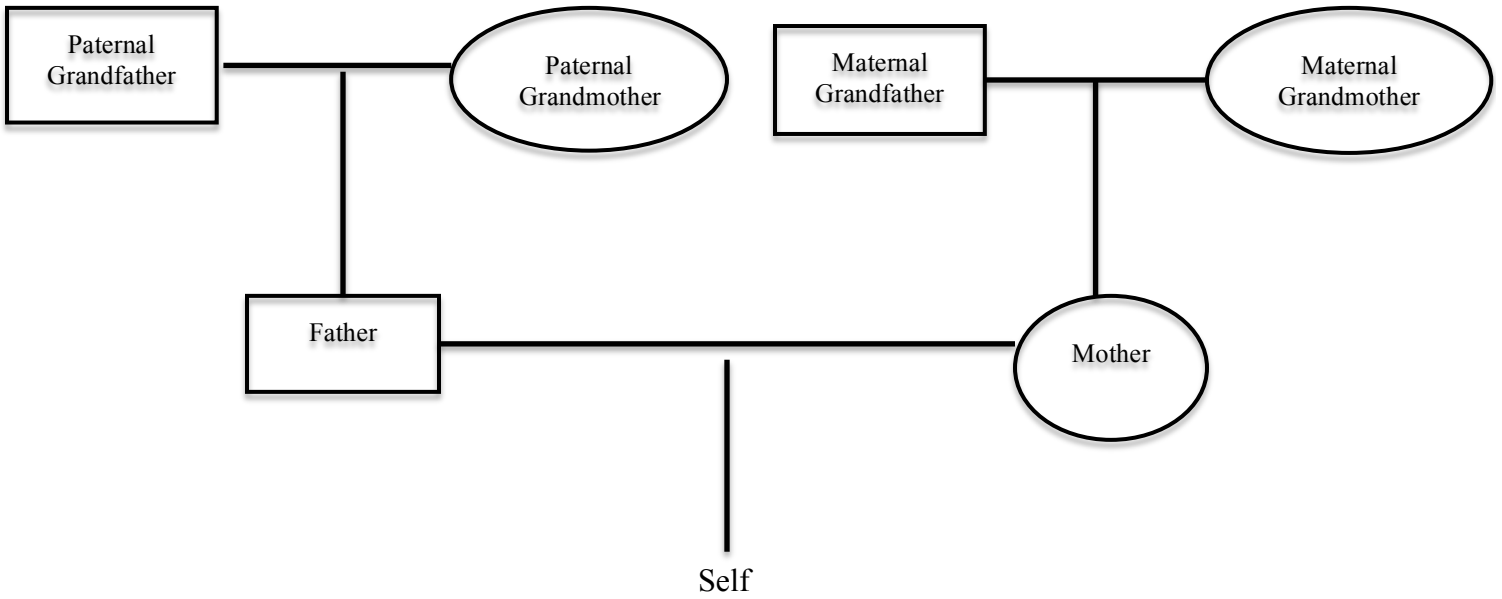
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**FAMILY OF ORIGIN HISTORY**

*What were the major stressors in your Family of Origin?* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*How did your Family of Origin deal with these stressors?* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Circle the words and phrases that are most descriptive of the way your Family of Origin operated*

<b>Lenient/Permissive</b>	<b>Open</b>	<b>Closed</b>
Rules are not enforced	Rules are Reasonable	Rules are strict
Spoils	Nurtures	Punishes
Unstructured	Structured	Rigidly structured
Unsupervised	Supervision	Rigidly supervised
Disorganized	Flexible	Chaotic or rigid
Ungrounded thinking	OK to think for self	Thinking is done for you
Choices are ignored	Choices	Choices are strictly limited
Lack of direction	Appropriate guidance	Dictatorial
Overly tolerant	Tolerant	Intolerant
Verbal/physical abuse is ignored	Verbally/physically respectful	Verbally/physically abusive
Tirades are ignored	Emotions are allowed	Emotionally are punished
Abandoning	Healthy	Abusive
Lost	Freeing	Enslaving

*As a child:*

*Who reliably provided you with comfort/nurturance?* \_\_\_\_\_

*Who reliably provided you with safety/protection?* \_\_\_\_\_

*Who reliably provided you with love/acceptance?* \_\_\_\_\_

*Who reliably provided you with a sense of being seen, heard, or connected with?* \_\_\_\_\_

*Who, if anyone, scared or terrified you?* \_\_\_\_\_

*Who, if anyone, was confusing or inconsistent with caring?* \_\_\_\_\_

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**RELATIONAL STYLE**

This information helps identify how you relate to yourself, others and the world around you. Identifying patterns can help with the counseling process.

List 5 words to describe your relationship with your Mother

\_\_\_\_\_

List 5 words to describe your relationship with your Father

\_\_\_\_\_

Which parent were you closer to? And what made that so?

\_\_\_\_\_

List 5 words to describe your relationship with your Closest Sibling

\_\_\_\_\_

List 5 words to describe your relationship with your Least Close Sibling

\_\_\_\_\_

List 5 words to describe your relationship with your Closest/Most Significant Relationship - Today

\_\_\_\_\_

List 5 words to describe your **relationship with your Self**

\_\_\_\_\_

When you are pleased with a personal accomplishment today, how do you respond?

\_\_\_\_\_

When you are upset with a personal disappointment today, how do you respond?

\_\_\_\_\_

Do you tend to.....

\_\_\_ Avoid

\_\_\_ Please/Appease

\_\_\_ Achieve/Compensate

\_\_\_ Combination



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**PERSONAL HISTORY AND CURRENT EXPERIENCES**

Personal History of learning, emotional, behavioral problems: yes\_\_ no\_\_

\* If yes, please explain \_\_\_\_\_

Personal History of addiction (alcohol, drug, Rx, food, sex, gambling, shopping, etc): yes\_\_ no\_\_

\* If yes, please explain \_\_\_\_\_

Personal History of family violence: yes\_\_ no\_\_

\* If yes, please explain \_\_\_\_\_

Personal History of criminal activity: yes\_\_ no\_\_

\* If yes, please explain \_\_\_\_\_

Personal History:

Abused (circle all that apply):    Physically       Emotionally       Spiritually       Mentally       Sexually

Neglected (circle all that apply):    Physically       Emotionally       Spiritually       Mentally       Sexually

*Which - if any - emotional regulation difficulties do you currently experience? How often do they occur?*  
(Always=1, Frequently=2, Sometimes=3, Seldom=4, Never=5)

\_\_\_ Rage→Self    \_\_\_ Rage→Others    \_\_\_ Numb    \_\_\_ Sad    \_\_\_ Panic    \_\_\_ Jealous  
\_\_\_ Overwhelmed    \_\_\_ High/Lo    \_\_\_ Guilt    \_\_\_ Shame    \_\_\_ Grief    \_\_\_ Disgust

*Which - if any - thought regulation difficulties do you currently experience? How often do they occur?*  
(Always=1, Frequently=2, Sometimes=3, Seldom=4, Never=5)

\_\_\_ Worry    \_\_\_ Looping    \_\_\_ Scary/Fearful    \_\_\_ Worst Case Scenario  
\_\_\_ Self-Harm    \_\_\_ Suicidal    \_\_\_ Uncontrollable    \_\_\_ Other People's Thoughts  
\_\_\_ Blank    \_\_\_ Distracted    \_\_\_ Forgetful/Unable to Recall

*Which - if any - body regulation difficulties do you currently experience? How often do they occur?*  
(Always=1, Frequently=2, Sometimes=3, Seldom=4, Never=5)

\_\_\_ Heart Racing    \_\_\_ Holding Breath    \_\_\_ Short/Shallow Breath    \_\_\_ Digestive Issues  
\_\_\_ Tight Muscles    \_\_\_ Unable to Speak    \_\_\_ Fidgety    \_\_\_ Aches/Pain  
\_\_\_ Cold    \_\_\_ Hot/Sweat    \_\_\_ Unaware of my Body

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*Any – recent body changes?* (circle all that apply):

Loss of energy/fatigue	Lost weight	Gained weight	Less Sleep
Appetite change	Lack of Focus	Hyper Focus	More Sleep
Other _____			

*Relational Concerns* (circle all that apply):

Unable to be alone	Isolate Often	Agitated	Shutdown
Taken Advantage of	Distracted	Impulsive	Anger Outbursts
No Boundary	Wall for Boundary	Confused Boundary	
Other _____			

*Self-Concerns* (circle all that apply):

Trance-like episodes/lost track of time	Childhood amnesia after age 5
Sudden flood of memories -past feels present	Things of yours go missing
Things appear but you don't know origin	Feel like I'm not me
Other _____	

*Other Stressors* (circle all that apply):

Separated from a parent (how long and what age) _____		
Death (parent, family member, friend, pet)	Incarcerated family member	
Medical Issue	Natural Disaster	Unusual, terrifying experience
Abortion	Placing child for adoption	Parenting/Discipline problems
Other _____		

*What are your ideas of God, Spirituality, and/or Faith?*

Unreliable	Consistent	Strictly rule-bound
Illogical	Balanced	Extreme
Best ignored	Safe	Demanding
Disinterested/unconcerned	Caring	Angry
Unavailable	Always available	Punishing
Too busy for me	Reliable	Harsh
None	Present	Intolerant

*Do you consider yourself*     *religious*     *spiritual*     *agnostic*     *atheist*     *other* \_\_\_\_\_

*I currently participate in regular meditation, prayer, or spiritual activities*     *Yes*     *No*

*List your current most helpful coping or calming strategies?*

- |    |    |
|----|----|
| 1) | 3) |
| 2) |    |

*What are the top 3 things you avoid regularly?*

- |    |    |
|----|----|
| 1) | 3) |
| 2) |    |

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*What is your current support system? How is it supportive for you?* \_\_\_\_\_

\_\_\_\_\_

*Who do you currently live with and how long have you lived with them?* \_\_\_\_\_

\_\_\_\_\_

*Do you have a best friend? Y / N*

*List 5 words to describe your current relationship with your best friend*

\_\_\_\_\_

*Check what applies, note the number and timeframe: (ie: divorced 1<sup>st</sup>, 5 months)*

\_\_\_\_\_ *single-never married*    \_\_\_\_\_ *engaged*    \_\_\_\_\_ *married*    \_\_\_\_\_ *divorced*

*Number of pregnancies* \_\_\_\_\_    *Number of children* \_\_\_\_\_

*How old are your children? What age did you give birth?*

\_\_\_\_\_

\_\_\_\_\_

*Age of puberty onset (menses for female)*

\_\_\_\_\_

*How did you learn about sex and how old were you?* \_\_\_\_\_

\_\_\_\_\_

*Age of first sexual experience* \_\_\_\_\_ *pleasant*    \_\_\_\_\_ *unpleasant*

*List 5 words to describe your current relationship with your sexuality*

\_\_\_\_\_

*How old were you when you got your first job?*


\_\_\_\_\_

*Are you satisfied at work? Y / N*

*List 5 words to describe your current job situation*

\_\_\_\_\_

**NEGATIVE BELIEFS ABOUT SELF**

 **Please note this is a long list of negative ideas. If this is too upsetting, please move to the next section which includes a list of preferred positive beliefs.**

*Please circle up to 5 negative beliefs that give you a feeling in your body and/or "feels true" when you are upset.*

I'm not good enough	I deserve to die	It's not ok (safe) to feel/show emotions
I don't deserve love	I deserve to be miserable	I am not in control
I am a bad person	I am different/I do not belong	I am powerless/helpless
I am incompetent	I must be perfect	I cannot get what I want
I am worthless/inadequate	It is my fault	I cannot stand up for myself
I am shameful	I should have done something/more	I cannot let it out
I am unlovable	I should have known better	I cannot trust myself
I deserve only bad things	I cannot trust anyone	I cannot trust my judgment
I am stupid/not smart enough	I cannot protect myself	I cannot succeed
I am insignificant/unimportant	I am in danger	I have to be perfect
I am a disappointment	I am not safe	I can't handle it

*When was the first, or worst, time you recall experiencing this negative felt sense or belief? Please write down a 'label' for the event, note how old you were and then note your upset level now as you recall the experience, where 0 feels neutral and 10 feels as upset as possible. (ie: I'm not safe, 'dog bark', 5y/o, upset of 5 now.)*

1)

2)

3)

4)

5)

**PREFERRED POSITIVE BELIEFS ABOUT SELF**

 **Please note this is what you would rather believe about yourself.**

*Please circle the positive self-beliefs that you would like to know at your core, even when you are upset.*

I am good enough as I am	I deserve to live	I can safely feel my emotions
I deserve love/ I can have love	I deserve to be happy	I am now in control
I am a good (loving) person	It's ok to be me/I do belong	I now have choices
I am competent	I can make mistakes and be ok	I can now get what I want
I am worthy/adequate	It is not my fault	I can make my needs known
I am honorable	I can be healthy	I can choose to let it out
I am loveable	I did the best I could/I can learn from it	I can be trusted
I deserve good things	I do the best I can	I can/learn to trust my judgment
I am intelligent/able to learn	I can choose who to trust	I can succeed
I am significant/important	I can learn to protect myself	I can be myself/make mistakes
I am fine just the way I am	It's over; I am safe now	I can handle it

*Can you list up to 5 experiences where your positive belief felt true? Please rate, where 1 feels false and 7 feels true.*

1)

2)

3)

4)

5)

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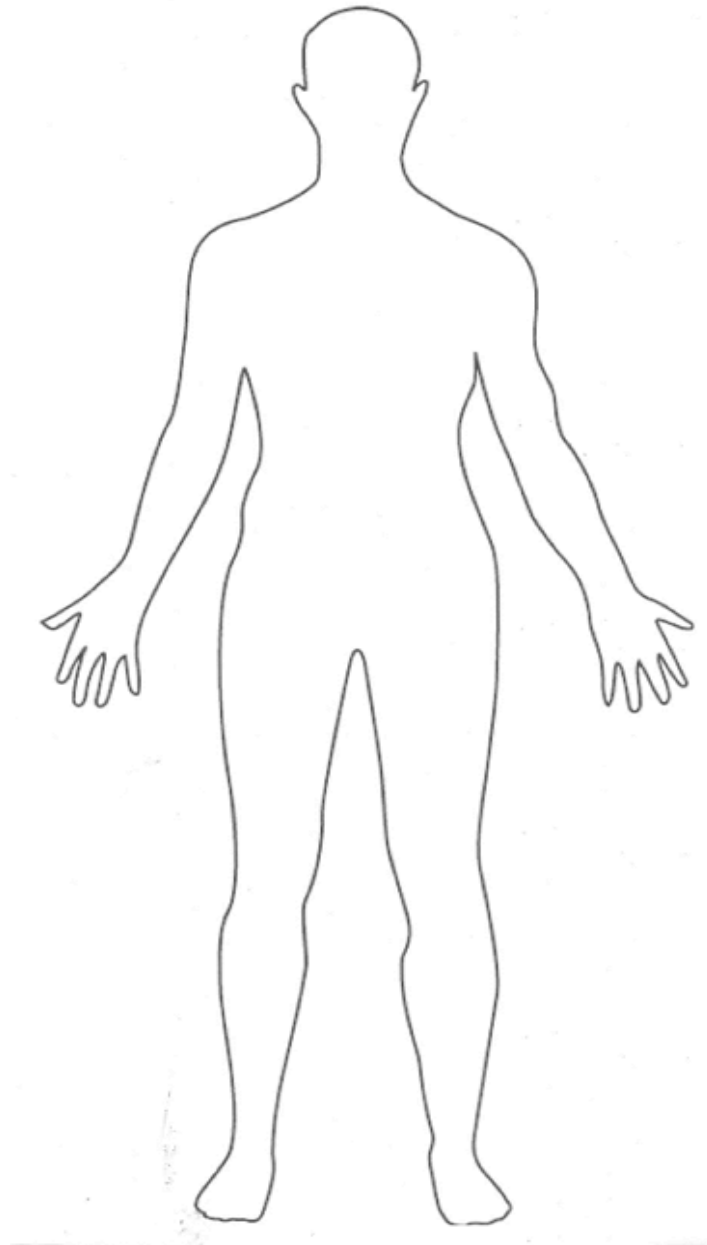
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**YOUR BODY**

How do experience your body? Please circle the area where you notice distress and describe the experience. Please draw an arrow to the areas you experience calm and describe the experience.



**CURRENT LIFESTYLE**

*Current use of Computer, Television* (circle the number of hours that best describes use):

*Computer/Internet* (circle approximate hours spent each week):

0-2    3-5    6-8    9-11    12+

*TV/NetFlix, etc* (circle approximate hours spent each week):

0-2    3-5    6-8    9-11    12+

*Current eating habits: I eat an estimated \_\_\_\_\_(number) of meals per day.*

*I eat when I'm hungry* \_\_\_ Yes \_\_\_ No. *Approximately \_\_\_\_\_% of the time.*

*I stop when I'm full* \_\_\_ Yes \_\_\_ No. *Approximately \_\_\_\_\_% of the time.*

*I would say my current eating lifestyle supports my overall health and well-being* \_\_\_ Yes \_\_\_ No.

*Currently I exercise \_\_\_\_\_ days a week for roughly \_\_\_\_\_minutes per day at approximately \_\_\_\_\_ intensity level*

*I participate in cardio activities* \_\_\_ Yes \_\_\_ No.

*I participate in weight training activities* \_\_\_ Yes \_\_\_ No.

*Current Caffeine Intake: I drink an estimated average of \_\_\_\_\_ cups of caffeine per day.*

*Current Nicotine Intake: I smoke/dip/vape estimated average of \_\_\_\_\_ times per day.*

*Current Alcohol Intake: I drink an estimated average of \_\_\_\_\_ alcoholic beverages per day.*

*Current Recreational Drug Use: I use \_\_\_\_\_ an estimated average of \_\_\_\_\_ times per day.*

*I would say I have an addictive personality* \_\_\_ Yes \_\_\_ No.

*Current Sleep habits: I get an estimated average of \_\_\_\_\_ hours of per night.*

*Currently I have nightmares* \_\_\_ Yes \_\_\_ No. *On average of \_\_\_\_\_(# of) nights per week.*

*Overall I would say I live a healthy lifestyle?* \_\_\_ Yes \_\_\_ No.

**PERSONAL REFLECTIONS**

*Overall, I would say I am a \_\_\_\_\_ person, when not experiencing my current symptoms.*

*My personal mantra/motto is \_\_\_\_\_*

*I would consider myself an introvert or extrovert (circle one).*

*I have a current source(s) of friends, family or loved ones that I feel connected to/with \_\_\_\_ Yes \_\_\_\_ No.*

*I have a current pet(s) that I adore \_\_\_\_ Yes \_\_\_\_ No.*

*In my role as a - career person, student, homemaker, business owner, caretaker, other \_\_\_\_\_  
(circle one) - I am generally satisfied and/or I gain positive esteem from this part of my life \_\_\_\_ Yes \_\_\_\_ No.*

*I have hobbies/interests that I enjoy and partake in regularly \_\_\_\_ Yes \_\_\_\_ No.*

*I would like to do more \_\_\_\_\_*


*I would like to do less \_\_\_\_\_*

*How do you spend your free time? Is it enjoyable to you? \_\_\_\_\_*

---

*5 personal values/traits I live by are:*

- |    |    |
|----|----|
| 1) | 4) |
| 2) | 5) |
| 3) |    |

* You Have Done A Lot of Introspective Work! Please Take Some Time to Participate in Something Pleasant or Restful for At Least 20 Minutes.*