Debbi J. Dunbar, MS, LPC

PARK PLAZA

2501 Parkview Drive| Suite 304 | Fort Worth, TX 76102 | 817.739.2421

www.debbidunbar-lpc.com

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. Note when these concerns began (note age or timeframe), the frequency you are affected (0-rarely…7-daily), level of upset when concerns occur (0-minimal....10-highly distressing):

1)

2)

3)

4)

How have you addressed the areas of concern listed above? Note if your previous efforts 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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HEALTH

Primary Care Physician: ____May I contact? Y / N
Name

____
City/State Phone

*Date of LAST complete physical*_______________ *Status of Physical* ______________________

Psychiatrist: ____May I contact? Y / N
Name

____
City/State Phone

Do you have an existing diagnosis? No___ Yes___ *If yes, when did you receive the diagnosis?* ____________

If yes, who provided the diagnosis? ____

**Check the any of the following items that apply, please list the prescriber for medication management.*

Diagnosis	Current	Past	Date of Diagnosis	Medication Name/Dosage	Prescriber
Depression	_____	_____	________________	________________________	___________
ADHD Hyperactive/Inattentive	_____	_____	________________	________________________	___________
Learning Disability	_____	_____	________________	________________________	___________
Anxiety/ Nervousness	_____	_____	________________	________________________	___________
Panic Attack	_____	_____	________________	________________________	___________
Bipolar	_____	_____	________________	________________________	___________
Mood Disorder	_____	_____	________________	________________________	___________
Insomnia/ Sleeplessness	_____	_____	________________	________________________	___________
Obsessive/ Compulsive	_____	_____	________________	________________________	___________
Addictions	_____	_____	________________	________________________	___________
Other	_____	_____	________________	________________________	___________

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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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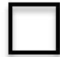
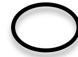
GENOGRAM

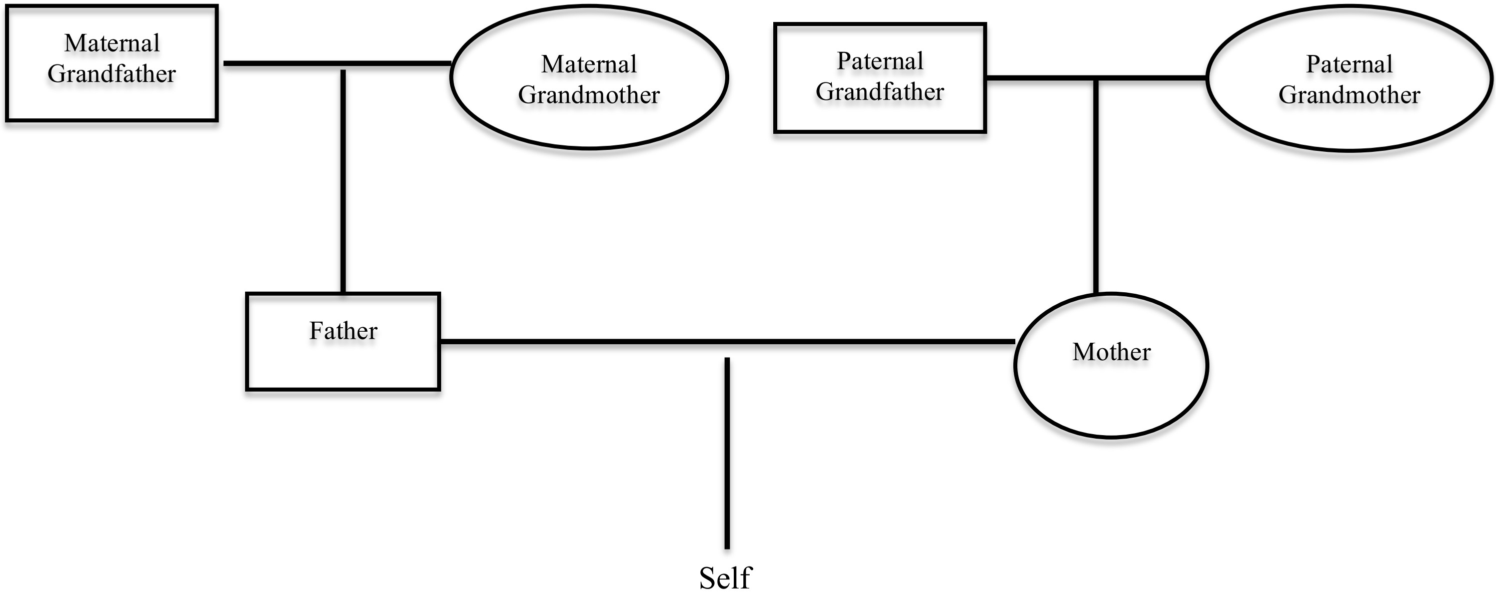
Family of Origin is the family you were born into or the family that raised you. Knowing the history and relationships within your family can be helpful during our work together. Please use the next page to draw your family genogram. This page is a general guide to help you create your genogram.

 = 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-parents(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 bi-polar), 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


Maternal Grandfather
Maternal Grandmother
Paternal Grandfather
Paternal Grandmother
Father
Mother
Self

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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

Lenient/Permissive	Open	Closed
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 to you respond?

____

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

____

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 1st, 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

__________ __________ __________ __________ __________

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PERSONAL HISTORY

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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Circle which - if any – recent body changes?

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*

List your current most helpful coping or calming strategies?

1) *4)*

2) *5)*

3)

What are the top 3 things you avoid regularly?

1) *3)*

2)

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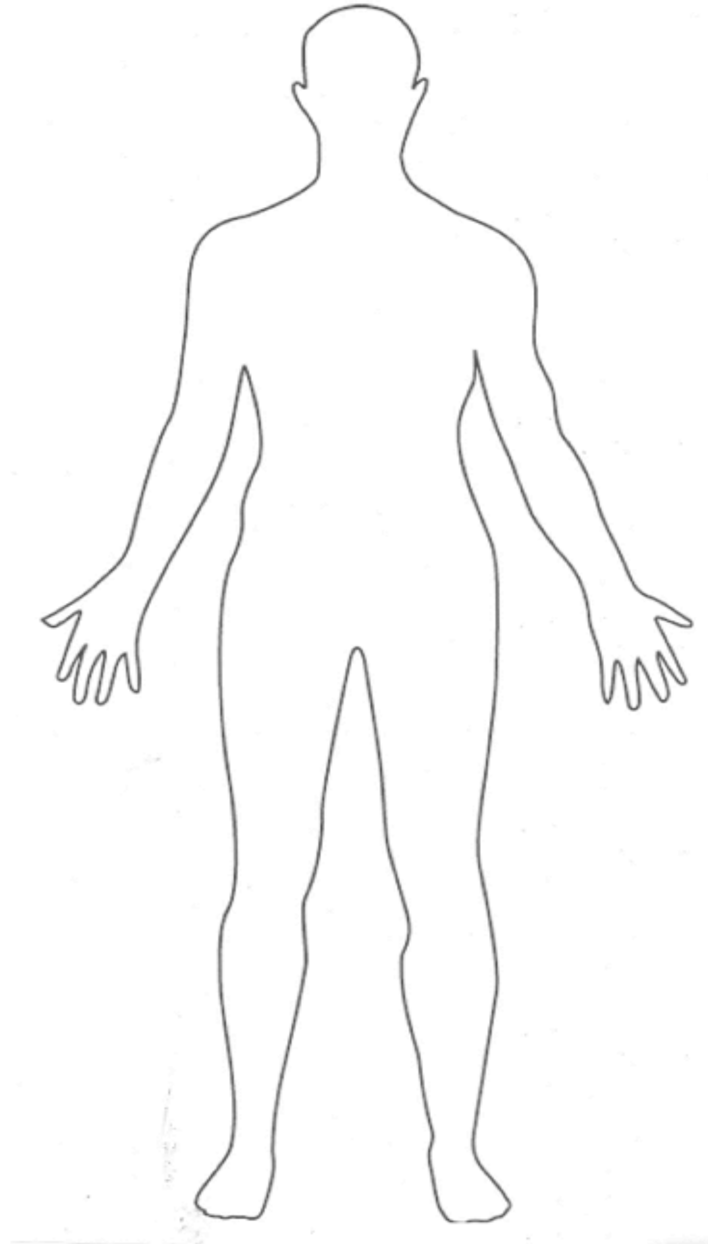
How do experience your body? Please circle the area where you notice distress and describe the experience. Please draw an arrow to the areas you experience calm and describe the experience.



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CURRENT LIFESTYLE QUESTIONS

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. ____ I participate in weight training activities.

Current Caffeine Intake: I drink an estimated average of ______ cups of caffeine 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

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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? ____
____

I participate in regular meditation, prayer, or spiritual activities ___ Yes ___ No.

5 personal values/traits I live by are:

1)

2)

4)

5)