Debbi J. Dunbar, MS, LPC
PARK PLAZA
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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

_____

Are you seeking EMDR Therapy? No___ Yes___

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 these concerns began (note age or timeframe)? How frequent 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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MEDICAL INFORMATION

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.

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

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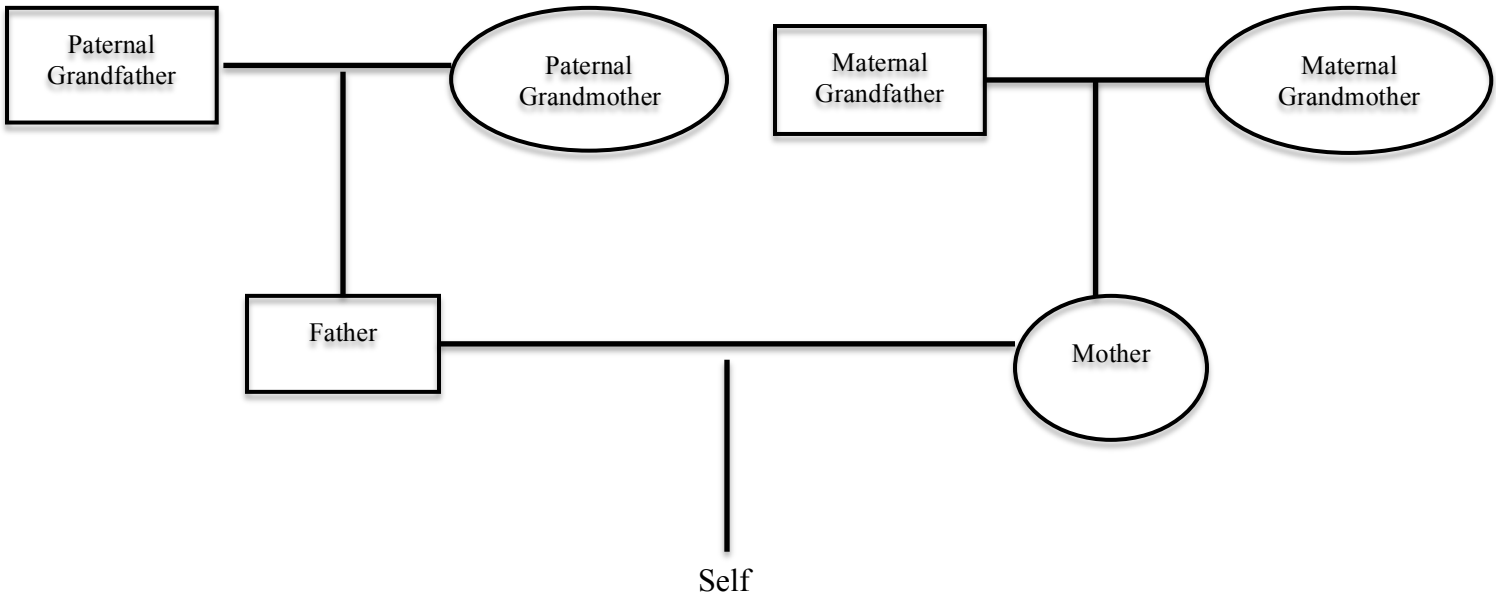

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FAMILY OF ORIGIN HISTORY

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

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?

_____

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 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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NEGATIVE BELIEFS ABOUT SELF

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

Please circle up to 5negative 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 at time of the event and then note your upset level <u>now</u> 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)

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PREFERRED POSITIVE BELIEFS ABOUT SELF

Please note this is what you would <u>rather</u> 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

List up to 5 experiences where your positive beliefs <u>felt true</u>. Please write down a 'label' for the event, how old you were at the time of the event, and then rate how true the belief feels <u>now</u>, where 1 feels false and 7 feels like a fact (ie: I am capable, 'difficult conversation goes well', 23y/o, feels like a 7 now).

1)

2)

3)

4)

5)

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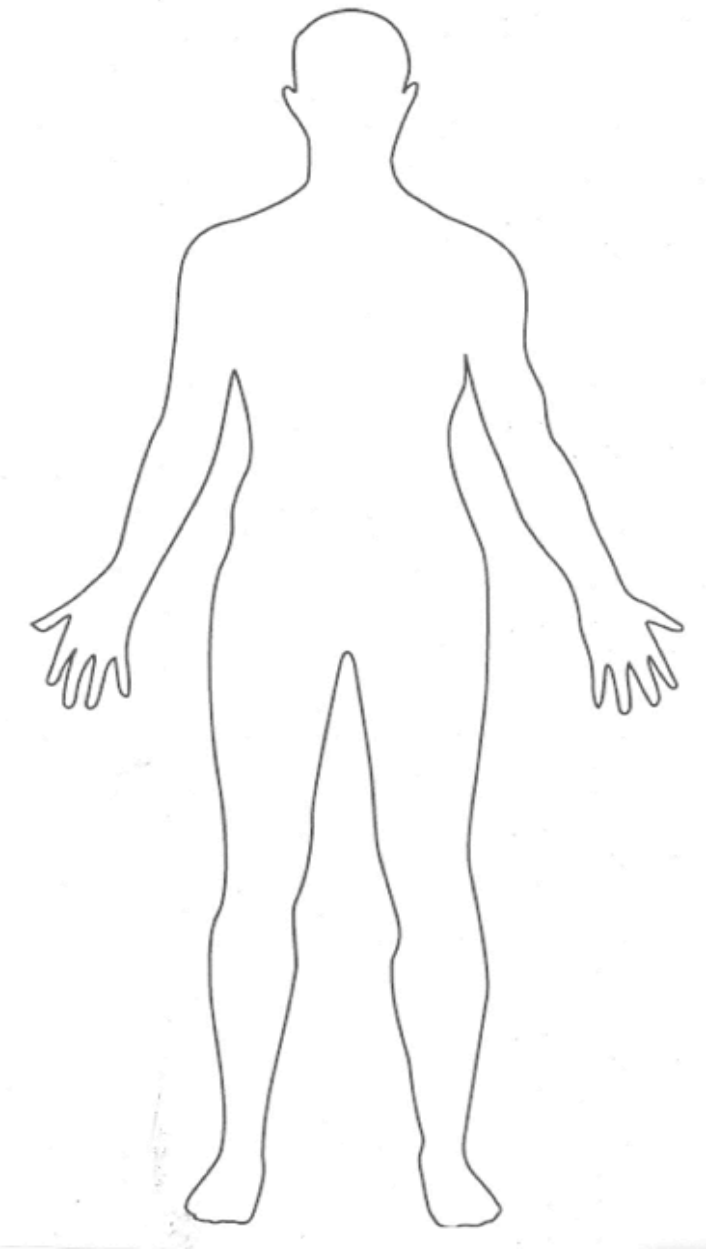
YOUR BODY

How do <u>experience</u> 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

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.

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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? _____

_____

5 personal values/traits I live by are:

1)
2)
3)
4)
5)

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