SunStone WELLNESS

Confidential Personal Information

Today's date: _____
Full Name: _____Age:_____Birthdate:_____
Address: _____City:_____State:_____Zip:_____
Phone: Home □ or cell □_____Work:_____
Email:_____Best way to contact you?_____
Occupation:_____Employer:_____
Emergency contact:_____phone:_____
Marital status: ☐ Married ☐ Single ☐Divorced ☐Widowed ☐Live with partner
How did you hear about SunStone Wellness? _____

Personal Health History

What are your concerns for which you are seeking care? (List in order of priority)
1. _____Date of onset:_____
2. _____Date of onset:_____
3. _____Date of onset:_____

What forms of treatment have you sought for your main health concerns?

Who do you see for health concerns? If Known:
Primary Doctor:_____Phone:_____
Integrative care:_____Phone:_____
Counselor:_____Phone:_____
Other:_____Phone:_____

What medications (prescribed or over the counter), herbs, vitamins, etc. are you taking?

Name	Dose	Reason for taking	For how long

Are you allergic to any medications? _____
Are you allergic to any foods or other substances? _____

Please identify the following health issues with dates:
Hospitalizations: _____
Injuries: _____
_____
Serious Illnesses: _____
Surgeries: _____
_____

Denise DeForest Pastoor, MEd, PMHCNS-BC, CHTP/I, E-RYT
www.sunstonewellness.com (919) 590-5769 denise@sunstonewellness.com

Family:

Children: name and ages: _____

_____

Who lives in your home with you?_____

Family history of:

☐ cancer _____	☐ arthritis	☐ obesity	☐ mental illness
☐ heart disease	☐ fibromyalgia	☐ Alzheimer's dz	☐ depression
☐ high blood pressure	☐ diabetes	☐ dementia	☐ anxiety

Lifestyle Habits

	How Much?	How Often?	Type?
Tobacco			
Coffee			
Tea			
Soft Drinks			
Alcohol			
Recreational Drugs			
Drink water			
Food cravings			

Briefly describe your typical diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Sleep Habits: (if yes, give number of days/week)

Hours of sleep/night: _____ Time go to bed: _____ Time awaken: _____

Difficulty falling asleep? _____ Staying asleep? _____ Early AM awakening? _____

Frequent nightmares? _____ Awaken tired? _____ Awaken refreshed? _____

Describe other sleep difficulties**:** _____

Energy level (0=exhausted, 10= optimal energy): _____

Appetite (0= no appetite, 10= voracious appetite): _____

Mood (0=very depressed, 10= very happy): _____

Stress (0= no stress, 10= extremely stressed)_____

Genogram: (to be completed by psychotherapist)

Denise DeForest Pastoor, MEd, PMHCNS-BC, CHTP/I, E-RYT
www.sunstonewellness.com (919) 590-5769 denise@sunstonewellness.com

Review of Symptoms:

Place check if you have any symptoms currently or in the past 6 months.
Place "P" is you had symptom in past, over 6 months ago.

General
Height _____
Weight _____
___ Recent weight gain
___ Recent weight loss
___ Fatigue

Skin
___ Acne
___ Eczema
___ Brittle nails
___ Fungal infections
___ Hair loss
___ Dry skin/ scalp
___ Night sweats
___ Flushing/ Hot flashes

Eyes/ Ears
___ Glaucoma
___ Cataracts
___ Near-sighted
___ Far-sighted
___ Poor night vision
___ Watery eyes
___ Dry eyes
___ Wear glasses
___ Wear contacts
___ Lasik surgery hx
___ Ringing in ears
___ Hearing loss:
___ Right ___ Left
___ Earaches / infections

Neurological
___ Seizures
___ Epilepsy
___ Paralysis
___ Muscle weakness
___ Numbness/ Tingling
___ Vertigo/ dizziness
___ Tics
___ Tourette's syndrome
___ Parkinson's dz
___ Alzheimer's dz
___ Dementia
___ ADD
___ ADHD

Head/ Neck
___ Tension Headaches
___ Migraines
___ Head injury
___ Neck stiffness
___ Jaw pain
___ TMJ
___ Goiter

Mouth/ Nose/ Throat
___ Canker sores in mouth
___ Cold sores
___ Teeth grinding
___ Excessive saliva
___ Gum problems
___ Sinus infections
___ Poor sense of smell
___ Sore throat
___ Nose bleeds
___ Allergies
___ Difficulty swallowing
___ Gags/ chokes easily
___ Bad breath/ Halitosis

Respiratory
___ Chest congestion
___ Coughing
___ Asthma
___ Shortness of breath
___ Pneumonia
___ Emphysema
___ Pain on breathing
___ Tuberculosis

Cardiovascular
___ Heart disease
___ High blood pressure
___ High cholesterol
___ Angina/ chest pain
___ Heart palpitations
___ Heart murmur
___ Low blood pressure
___ Swelling in ankles
___ Varicose veins
___ Cold hands/ feet
___ Deep vein pain
___ Bruises easily

Immune System
___ Chronic Fatigue Synd.
___ Fibromyalgia
___ Multiple Sclerosis
___ Frequent colds
___ Positive HIV
___ AIDS

Endocrine/ Urinary
___ Kidney stones
___ Hyperthyroid
___ Hypothyroid
___ Diabetes
___ Hypoglycemia
___ Heat/Cold intolerance
___ Increase thirst/hunger
___ Bladder infections
___ Urination at night
___ Edema/Ankle swelling

Gastrointestinal
___ Indigestion
___ Heartburn
___ Ulcers
___ Nausea/ Vomiting
___ Anorexia/ Bulemia
___ GI cramping
___ Gas/ Bloating
___ Belching/ Flatulence
___ Diarrhea
___ Constipation
___ Irritable Bowel Syndr.
___ Hemorrhoids
___ Jaundice
___ Gallbladder problems
___ Liver problems
___ Crohn's disease
___ Ulcerative colitis

Musculoskeletal
___ Joint Pain/ stiffness
___ Arthritis
___Osteoporosis
___ Shoulder/ Knee pain
___ Back pain
___ Fractures
___ Foot pain
___ Restless Leg Syndrom
___ Sciatica

Male only
___ Hernia
___ Testicular pain
___ Testicular masses
___ Prostate disease
___ Sexually transmit.dz
___ Difficulty urinating
Sexually active? _____

Female only
Age menses onset _____
Perimenopausal? _____
Menopausal? _____
Age last menses _____
Sexually active? _____
Birth control _____
___ PMS
___ Painful menses
___ Ovarian cysts
___ Sexually transmit. dz
___ Pain with intercourse
___ Vaginal discharge
___ Breast tenderness
___ Breast lump
Mammogram_____
PAP _____
Other feminine issues?
_____

Mental Health
___ Depressive Disorder
___ SADDS (seasonal)
___ Chronic
___ Post-partum
___ Suicidal ideation
___ Bi-Polar Disorder
____ I. ___ II. (soft)
___ Anxiety Disorder
___ Social
___ Obsessive/Compul.
___ GAD
___ Phobias
___ Panic disorder
___ PTSD-Trauma
___ Thought Disorder
___ Schizophrenia
___ Psychosis
___ Substance Abuse
___ Alcohol Abuse

Denise DeForest Pastoor, MEd, PMHCNS-BC, CHTP/I, E-RYT
www.sunstonewellness.com (919) 590-5769 denise@sunstonewellness.com

Psychosocial History

Who are your support systems? _____
Religious affiliation? _____Church_____
Spiritual beliefs? _____
Volunteer activities: _____
Hobbies: _____

1. What do you do for relaxation? Engage in meditation practice?

_____

2. What lifestyle habits do you engage in regularly for that you believe support your health?

_____

3. What do you love most about your life at this time?

_____

4. What lifestyle habits do you engage in regularly that are harmful to your health?

_____

5. What stresses you the most in your life at this time?

_____

6. What is your present level of commitment to address any causes of your symptoms that relate to lifestyle? (Rate 0-10 with 0= no commitment 10= full commitment): _____

7. What are your overall health goals?

_____

Informed Consent--Integrative Health therapies

Integrative health therapies are therapeutic approaches in holistic health practices to allow individuals to access their natural healing abilities. Integrative Health therapies may include, but are not limited to Healing Touch, energy therapies, EFT, HeartMath, trigger point therapy, acupressure, aromatherapy, body-based movement, Ebb & Flow™, yoga, chair yoga, aqua yoga, aerial yoga, and contemplative wisdom practices, which may include mindfulness and/or meditation.

The primary purpose of using integrative health therapies, in conjunction with holistic psychotherapy, is to support the body's natural healing response, promote stress resilience, activate the relaxation response, and promote personal growth.

I understand that the intention for all therapeutic integrative health and holistic psychotherapy approaches is to promote optimal health and render no harm. I accept full responsibility for all outcomes of engaging in these integrative therapies. I hold SunStone Wellness, LLC, its owners, associates, trainers, assistants, students, and facilities or grounds where programs are held, harmless of any liabilities:

I understand that payment is due at time of service, with 24hour cancellation.

I understand that treatment is not a substitute of medical care and it is recommended I seek a qualified healthcare professional for approval to participate in any integrative therapies offered.

Signature: _____ **Date:** _____
(Signature of legal guardian or parent, if patient is a minor)

Intake form and informed consent reviewed: **Date:** _____
Signature of therapist:_____

Denise DeForest Pastoor, MEd, PMHCNS-BC, CHTP/I, E-RYT
www.sunstonewellness.com (919) 590-5769 denise@sunstonewellness.com