Third Space Wellness, LLC

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your information is confidential.

Personal Identifying Information and Contact

Legal Name		
Age	Date of Birth (mm/dd/yyyy)	Sex and/or Gender Identity
Street Address		City, State, and Zip Code
Preferred Phone Number		May we leave a message here? Circle: YES or NO
Preferred Email Address		

Emergency Contact Information

Name	Relationship to You
Preferred Contact Information	

Medical Providers & Referral Information

Primary Care Physician or Referring Physician	Phone Number
Street Address	City, State, and Zip Code
Primary Insurance Carrier: _____ Insurance Phone Number: _____	Policy Identification Number: _____ Group Number: _____
Policy Subscriber Name: _____ Relationship to Patient: _____	Do you have a referral for acupuncture? Circle: YES or NO
Policy Subscriber Address (Street/City/State/Zip)	Policy Subscriber Phone Number
Secondary Insurance Carrier: _____ Insurance Phone Number: _____	Policy Identification Number: _____ Group Number: _____
Policy Subscriber Name: _____ Relationship to Patient: _____	Do you have a referral for acupuncture? Circle: YES or NO
Policy Subscriber Address (Street/City/State/Zip)	Policy Subscriber Phone Number

Chief complaint(s); tell us about why you've come for treatment:

_____

_____

History of Procedures

If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please include each below (not including normal pregnancies):

Year	Operation/Illness	Hospital or Treatment Location

History of Trauma (anything you have experienced as traumatic):

Medications/Vitamins/Supplements/Herbs

Please list all medications you are currently taking:

Medication	Dosage	For what condition?

Please list all vitamins, supplements, and/or herbs you are currently taking:

Vitamins, Supplements, Herb(s)	Dosage	For what condition?

Please attach a list of any additional medications/vitamins/supplements/herbs which will not fit above.

Personal Lifestyle Information

Do you exercise? Circle: YES or NO (If yes, please complete A & B)	(A) What kind of exercise?	(B) How often do you exercise?
Coffee/Tea (# cups per day):	Alcohol (# drinks per week):	Soda (regular or diet):
Cigarettes (# packs per day):	Recreational Drug Use:	

Personal and Family History

Please complete this as best as you can, indicating any illnesses that you or family members have ever had. Place an "X" or the date beside applicable family members and situations.

	Self Specific Diagnosis and Date	Family
Adopted		_____ Mother _____ Father _____ Sibling _____ Children _____ Spouse/Partner
Allergies		_____ Mother _____ Father _____ Sibling _____ Children _____ Spouse/Partner
Autoimmune Conditions		_____ Mother _____ Father _____ Sibling _____ Children _____ Spouse/Partner
Cancer or Tumors		_____ Mother _____ Father _____ Sibling _____ Children _____ Spouse/Partner
Deceased (age)		_____ Mother _____ Father _____ Sibling _____ Children _____ Spouse/Partner
Diabetes		_____ Mother _____ Father _____ Sibling _____ Children _____ Spouse/Partner
Drugs and/or Alcohol Difficulties		_____ Mother _____ Father _____ Sibling _____ Children _____ Spouse/Partner
Heart Disease (High Blood Pressure, Stroke, Blood Disorders, Anemia)		_____ Mother _____ Father _____ Sibling _____ Children _____ Spouse/Partner
HIV / AIDS		_____ Mother _____ Father _____ Sibling _____ Children _____ Spouse/Partner
Mental Illness		_____ Mother _____ Father _____ Sibling _____ Children _____ Spouse/Partner
Musculoskeletal disorders		_____ Mother _____ Father _____ Sibling _____ Children _____ Spouse/Partner
Seizures		_____ Mother _____ Father _____ Sibling _____ Children _____ Spouse/Partner
Thyroid Disorders		_____ Mother _____ Father _____ Sibling _____ Children _____ Spouse/Partner

Current and Past Conditions and Symptoms
Write "C" if you are currently experiencing any of the following
Write "P" if you have experienced any of the following in the past
Write "P-C" if you have experienced the condition both in the past and currently

General
___ Insomnia
___ Dreams/Nightmares
___ Fatigue
___ Poor Memory
___ Strongly like cold drinks
___ Strongly like hot drinks
___ Recent weight loss/gain
___ Cold hands & feet
___ Chills
___ Fever
___ Bad breath
___ Other (describe below)

Eyes
___ Glasses/contact lenses
___ Blurred vision
___ Poor night vision
___ Spots or floaters
___ Eye inflammation
___ Double vision
___ Glaucoma
___ Cataracts
___ "Lazy" eye
___ Other (describe below)

How often checked? _____

Urinary
___ Pain on urination
___ Frequent urination
___ Urgent urination
___ Blood in urine
___ Incontinence
___ Incomplete urination
___ Bedwetting
___ Wake to urinate
___ History of UTI
___ Kidney (describe below)

___ Other (describe below)

Head & Neck
___ Headaches
___ Migraines
___ Stiff neck
___ Dizziness
___ Fainting
___ Swollen glands
___ Other (describe below)

Musculoskeletal
___ Joint pain/swelling
___ Sore muscles
___ Weak muscles
___ Difficulty walking
___ Limited range of motion
___ Pain (describe below)
___ Other (describe below)

Ears
___ Ringing
___ Hearing loss
___ Hearing aids
___ Infections
___ Ear ache
___ Vertigo
___ Other (describe below)

Cardiovascular
___ High blood pressure
___ Low blood pressure
___ Chest pain or tightness
___ Palpitation
___ Rapid heart rate
___ Irregular heart beat
___ Poor circulation
___ Swollen ankles
___ Phlebitis
___ Anemia
___ History of heart disease
___ Heart murmur
___ Night sweats
___ Tendency to be cold
___ Tendency to be warm
___ Other (describe below)

Gastrointestinal
___ Nausea
___ Indigestion
___ Stomach pain
___ Diarrhea
___ Constipation
___ Poor appetite
___ Excessive hunger
___ Vomiting
___ Gas
___ Hiccups
___ Acid regurgitation
___ Bloating
___ Laxative use
___ Bloody stool
___ Other (describe below)

Mental/Emotional
___ Depression
___ Mood swings
___ Irritability
___ Difficulty relaxing
___ Loneliness
___ Sensitive
___ Shyness
___ Frequent crying
___ Worries frequently
___ Compulsive behaviors
___ Difficulty focusing
___ Hopeless outlook
___ Suicidal thoughts
___ Lose temper
___ Frustration
___ Other (describe below)

Current and Past Conditions and Symptoms, Continued

Skin
___ Hives Rashes
Eczema/psoriasis
___ Night sweating
___ Excess sweating
___ Dry skin
___ Easily bruised
___ Changes in moles, lumps
___ Itching
___ Other (describe below)

Neurological
___ Seizures
___ Tremors
___ Numbness or tingling
___ Paralysis
___ Poor coordination
___ Pain (describe below)
___ Other (describe below)

Sexual or Other Infections
(circle self and/or partner)

___ HIV risks: self or partner
___ TB: self or partner
___ Hepatitis risk: self or partner
___ Other (describe below)

Nose, Throat, & Mouth
___ Sinus infection
___ Hay fever / allergies
___ Frequent sore throat
___ Difficulty swallowing
___ Mouth & tongue ulcers
___ Frequent colds
___ Nosebleed
___ Dry nose
___ Nasal congestion
___ Loss of voice
___ Thirst
___ Excessive phlegm
___ TMJ
___ Facial pain
___ Gum problems
___ Dry mouth
___ Dental problems? (describe below)

___ Other (describe below)

Respiratory
___ Difficulty breathing
___ Difficulty breathing when reclining
___ Wheezing
___ Asthma
___ Chronic cough
___ Wet cough
___ Dry cough
___ Coughing up phlegm
___ Coughing up blood
___ Shortness of breath
___ Tight chest
___ Pneumonia
___ Other (describe below)

Male Genital (Male Only)
___ Impotence
___ Premature ejaculation
___ Nocturnal emission
___ Pain/itching of genitalia
___ Lumps in testicles
___ Increased libido
___ Decreased libido
___ Breast checked
___ Other (describe below)

Gynecology (Women Only)
___ Currently pregnant
___ # of Pregnancies
___ # of Live Births
___ # of Miscarriages
___ # of Abortions
___ Menopause
___ Irregular periods
___ Menstrual cramps
___ Excessive blood flow
___ Menstrual blood clots
___ Breast tenderness
___ Abnormal pap smear
___ Vaginal infections
___ Vaginal pain/itching
___ Uterine fibroids
___ Endometriosis
___ Breast lumps, cysts
___ Increased libido
___ Decreased libido
___ Other (describe below)

Is there anything else you'd like to report or that you'd like us to ask you about:

Please read and sign below:
I've completed this form to the best of my ability & certify that this is my personal health

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Patient Signature
(Or Parent/Legal Representative if patient is a minor/has a representative)

Today's Date (mm/dd/yyyy)