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		I prefer to be called:
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

Whom may we thank for referring you?

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

_____

_____

Medical Information

Primary Care Physician or Referring Physician	Phone Number
Street Address	City, State, and Zip Code
Date of last visit:	

Specialist Physicians; list the name, phone number and date of last visit for any specialists you work with:

Specialists	Phone number	Date of last visit

Previous mental health care? ____ Yes _____ No Diagnosis (if applicable):	Providers: 1)_____ 2) _____	Dates: 1) _____ 2) _____

Have you ever contemplated or atempted to physically hurt yourself or someone else? If yes, please provide details:

_____

_____

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 & Frequency	For what condition?

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

Vitamins, Supplements, Herb(s)	Dosage & Frequency	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?
Caffeine (# cups per day):	Alcohol (# drinks per week):	Do you have any dietary or nutrition concerns? If yes, please explain:
Cigarettes (# packs per day):	Recreational Drug Use:	
Average number of hours of sleep per night:	Quality of sleep: ____ satisfied ____ dissatisfied ____ I'd like improvement	
How would you rate your overall physical health: ____ Excellent _____ Good _____ Fair _____ Poor		

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**	**Family**
Adopted		_____ Mother _____ Father _____ Sibling _____ Children _____ Spouse/Partner
Deceased (age)	N/A	_____ Mother _____ Father _____ Sibling _____ Children _____ Spouse/Partner
Drugs and/or Alcohol Difficulties		_____ Mother _____ Father _____ Sibling _____ Children _____ Spouse/Partner
Mental Illness		_____ Mother _____ Father _____ Sibling _____ Children _____ Spouse/Partner

Concerns
Please put a check or an "x" next to any items that are areas of concerns for you.

___ Stress
___ Fatigue
___ Eating/Dietary Concerns
___ Boredom
___ Laziness
___ Sleeping too much
___ Sleeping too little
___ Weight gain
___ Weight loss
___ Panic
___ Difficulty sitting still
___ Procrastination
___ Smoking cessation
___ Drinking
___ Substance use/abuse
___ Relationship concerns
___ Family of origin concerns
___ Separation from loved ones/family
___ Isolation
___ Phobias
___ Anger management
___ Excessive planning
___ Disorganization
___ Nausea
___ Binging
___ Vomitting
___ Physical Pain
___ Concerns about health
___ Concerns about germs/cleanliness
___ Financial Planning
___ Intrusive thougths
___ Indecisiveness
___ Depression
___ Guilt
___ Worrying
___ Co-dependence
___ Difficulty walking
___ Loneliness
___ Fear
___ Past traumatic event
___ Sexual health concerns
___ Intimacy challenges
___ Coping
___ Life changing event(s)
___ Compulsive or repetitive behaviors
___ Gender/sexual identity
___ Workplace concerns
___ Employment concerns
___ Life transition concerns
___ Difficulty concentrating
___ Migraines
___ Stomach/digestion issues
___ Lack of fulfillment
___ Assertiveness
___ Self-esteem
___ Caregiver of a loved one
___ Parenting concerns
___ Difficulty moving on/letting go
___ Social anxiety
___ Suicidal thoughts/tendencies
___ Nightmares
___ Avoidance
___ Irritability
___ Gambling
___ Homicidal thoughts/behaviors
___ Saddness
___ Withdrawal
___ Difficulty breathing
___ Body image concerns

Please prioritize three items that are most important for you to address in therapy:

1) _____ 2) _____ 3) _____

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

_____
Patient Signature Today's Date (mm/dd/yyyy)
(Or Parent/Legal Representative if patient is a minor/has a representative)