360º Balance – Diagnostics & Therapy
Health History Questionnaire

All of the information that you provide in this questionnaire is strictly confidential and will become part of your medical record.

General Demographics

Patient Name: (First/MI/Last) ________________________________ Gender: ☐ M ☐ F

Date of Birth: (mm/dd/yyyy) _____ / _____ / ___________ Age: __________

Hand Dominance: ☐ Left ☐ Right ☐ Ambidextrous

How did you hear about our clinic? _____________________________________

Social History & Living Environment

Where do you live? Private Home ☐ Apartment ☐ Extended Care ☐ Hospice ☐
Assisted Living ☐ Board & Care ☐

With whom do you live? Alone ☐ Spouse ☐ Children ☐ Parents ☐ Siblings ☐
Relatives ☐ Friends ☐ Group Setting ☐

Social / Health Habits

Do you smoke tobacco? No ☐ Occasionally ☐ Socially ☐ Daily ☐ Heavily ☐

Do you drink alcohol? No ☐ Occasionally ☐ Socially ☐ Daily ☐ Heavily ☐

Do you use recreational drugs? No ☐ Occasionally ☐ Socially ☐ Daily ☐ Heavily ☐

Do you exercise? No ☐ Yes ☐ If yes, how many days per week? _____ minutes/day? ____

Describe exercise or activity: ____

Employment / Work

Work Status: Unemployed ☐ Full-Time ☐ Part-Time ☐ Student ☐ Homemaker ☐
Light Duty ☐ Disabled ☐ Retired ☐ Leave of Absence ☐

General Health Status

Please rate your health: Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't Know ☐

Life Changes (past year): None ☐ Death in Family ☐ New Job ☐ Divorce ☐ Move ☐

Family History

Please check if anyone in your family (blood relatives) has or had any of the following:

Heart Disease ☐ High Blood Pressure ☐ Cancer ☐ Psychological Problems ☐

Pulmonary/Lung Disease ☐ Diabetes ☐ Arthritis ☐ Stroke ☐ Osteoporosis ☐

Allergies ☐ Hearing Loss ☐ Vertigo ☐ Balance Problems ☐

Allergies

Airborne Pathogens: Yes ☐ No ☐ Please List: __________________________________

Are you receiving treatment for allergies? Describe: __________________________________

Your Past Medical History

	Pacemaker		Diabetes		Kidney Disease		Parkinson's Disease
	AIDS		Emphysema		Liver Disease		Prostate Disease
	Allergies		Epilepsy/Seizures		Low Blood Pressure		Skin Disorders
	Asthma		Glaucoma		Lung Disorder		Stroke
	Arthritis		Heart Attack		Lyme's Disease		Thyroid Disorder
	Blood Disorders		Heart Disease		Macular Degeneration		Ulcers (Stomach)
	Broken Bones		Circulation Problems		Meniere's Disease		Repeated Infections
	Hepatitis		Head Injury		Muscular Dystrophy		Reoccurring Vertigo
	Cancer		High Blood Pressure		Multiple Sclerosis		Depression
	Cystic Fibrosis		High Cholesterol		Osteoporosis		Genetic Disease

For Women Only: Pelvic Inflammatory Disease ☐ Trouble with Period ☐

Complicated Pregnancies ☐ Currently Pregnant ☐ Endometriosis ☐

Do you experience an increase in symptoms with hormonal changes? Yes ☐ No ☐

Surgical History

Please list any surgeries you have had and, if known, include dates:

1. ______________________ Year: _____ 2. _______________________ Year: _____
3. ______________________ Year: _____ 4. _______________________ Year: _____

Past Symptoms Checklist

	No Symptoms		Foggy Headedness		Shortness of Breath		Headaches
	Bowel Problems		Heart Palpitations		Syncope (Passing Out)		Tremors
	Chest Pain		Joint Pain/Swelling		Urinary Problems		Tinnitus
	Vertigo		Loss of Appetite		Cough (Persistent)		Hearing Loss
	Dizziness		Loss of Balance		Dizziness w/ Physical Exertion		Vision Problems
	Difficulty Driving		Pressure in Ears		Weakness in Arms/Legs		Fatigue
	Difficulty Walking		Nausea/Vomiting		Weight Gain (Unexplained)		Motion Sickness
	Pain at Night		Numbness in arms/legs		Weight Loss (Unexplained)		
	Excessive Sweating		Concentration Problems		Dizziness w/ Loud Noises		

Diagnostic Tests / Measures

	No Testing		Bronchoscopy		Hearing Test		Pulmonary Function Test
	Angiogram		CT Scan		Mammogram		Speech/Language Evaluation
	Arthroscopy		Ultrasound		MRI		Stool Test
	Biopsy		Echocardiogram		Pap Smear		Stress Test
	Blood Test		EEG		EMG/Nerve Conduction		Urine Test
	Bone Scan		EKG		ENG		X-Ray

Medications: See Attached List ☐

Or List Prescriptions: ____

Decongestants ☐ Vitamins ☐ Herbal Supplements ☐ Ibuprofen ☐ Aspirin ☐ Antihistamines ☐