DR. SUSAN L. STREIFF

Practice of Chiropractic

Date _____

PATIENT INFORMATION

Patient Name (Last, First MI)			
Street Address	City	State	Zip Code
Home Phone ( )	Work Phone ( )	Cell Phone ( )	Sex ☐ Female ☐ Male
Marital Status ☐ Single ☐ Married ☐ Other	Student Status ☐ Full Time ☐ Part Time ☐ N/A	Date of Birth Month___ Day ___ Year _____	
Employment Status ☐ Full time ☐ Part time ☐ Retired ☐ N/A	Employer		
Employer Address	State	Zip Code	
Person to Contact In Case of Emergency	Emergency Phone ( )	How did you hear about us?	
Any Other Information We Should Know About? (Allergies, Diet Restrictions, Other)			

Responsibility Statement

Your insurance is a method for you to receive reimbursement for fees you have paid the physician for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowance or percentages based on your contract with them, not our office. It is your responsibility to pay the deductible co-insurance and any other balances not paid by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill and your claims.

RESPONSIBLE PARTY – PLEASE COMPLETE IF PERSON IS NOT THE PATIENT

Responsible Party (Last, First, MI)	Relationship of Responsible Party to the Patient ☐ Self ☐ Spouse ☐ Child ☐ Other		
Street Address	City & State	Zip Code	
Home Phone	Work Phone		Date of Birth
Marital Status ☐ Single ☐ Married ☐ Other	Sex ☐ Male ☐ Female	Student Status ☐ Full Time ☐ Part Time ☐ N/A	
Employment Status ☐ Full time ☐ Part time ☐ Retired ☐ N/A	Employer Name		
Employer Address	State	Zip Code	

INSURANCE INFORMATION

☐ Have you provided the office with your insurance card(s) for copying? *Office verified:*_____

Note primary & secondary *(if applicable)* insurance company name(s): Primary: _____ Secondary:_____

Please pay co-payment (per your insurance agreement) at the time of your visit. Thank you.

DR SUSAN L. STREIFF
PRACTICE OF CHIROPRACTIC

135 N. Greenleaf, Suite 110
Gurnee, IL 60031
847-263-8900

1920 Waukegan Rd, Ste.7
Glenview, IL 60025
847-724-8680

Patient History

Name:_____ Date:_____

Chief Complaint:_____
How long have you had this condition? _____
Have you had this or similar conditions in the past?_____
How long has this episode been active?_____
Describe your injury:_____
Is this condition getting progressively worse? Yes___ No___ Constant___ Comes & Goes____
Is this condition interfering with your Work____ Sleep____ Daily routine____ Other_____
What aggravates the condition?_____
Does the pain radiate anywhere?_____
Is the pain intermittent or constant?_____
Describe your work activities:_____
Describe your recreational activities: _____
Other physicians seen for this conditions_____
Any X-Rays taken?_____Urinalysis_____Blood Tests_____Other_____
Are you taking any medications? Yes____ No_____ What kind? _____
Any non-prescription drugs? _____
Major illnesses?_____
Major Injuries?_____
Surgical operations?_____
Last physical examination and physician's name _____
Secondary complaints: _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize and request the performance of chiropractic services for myself and give my consent to any advisable and necessary procedures, laboratory and x-rays to be administered by the attending physician or by his/her supervised staff for diagnostic purposes and treatments.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____

MEDICAL HISTORY FORM

Print Name: _____

Check all applicable boxes.		
	☐ Diabetes	☐ Learning disabilities
	☐ Diverticular disease	☐ Liver or gallbladder disease –*(stones)*
	☐ Drug addiction	☐ Mental illness
☐ Arthritis	☐ Eating disorder	☐ Mental retardation
	☐ Epilepsy	☐ Migraine headaches
☐ Allergies/hayfever	☐ Emphysema	☐ Neurological problems (Parkinson's, paralysis)
☐ Asthma	☐ Eyes, ears, nose, throat problems	☐ Obesity
☐ Alcoholism	☐ Environmental sensitivities	☐ Osteoporosis
☐ Alzheimer's disease	☐ Fibromyalgia	☐ Pneumonia
☐ Autoimmune disease	☐ Food intolerance	☐ Seasonal affective disorder
☐ Blood pressure problems	☐ Gastro esophageal reflux disease	☐ Sinus problems
☐ Bronchitis	☐ Genetic disorder	☐ Skin problems
☐ Cancer	☐ Glaucoma	☐ Stroke
☐ Chronic fatigue syndrome	☐ Gout	☐ Thyroid problems
☐ Carpal tunnel syndrome	☐ Heart disease	☐ Tuberculosis
☐ Cholesterol, elevated	☐ Infection, chronic	☐ Ulcer
☐ Circulatory problems	☐ Inflammatory bowel disease	☐ Urinary tract infection
☐ Colitis	☐ Irritable bowel syndrome	☐ Varicose veins
☐ Depression	☐ Kidney or bladder disease	☐ Other:

Medical history (men only)		
☐ BPH	☐ Decreased sex drive	☐ STD
☐ Prostrate cancer	☐ Infertility	☐ Other:

Medical history (women only)		
☐ Menstrual irregularities	☐ Endometriosis	☐ Decreased sex drive
☐ PMS	☐ Pelvic inflammatory disease	☐ STD
☐ Date of last menstrual cycle ___/___/___	☐ # of children: _____	☐ Infertility
☐ Length of cycle _____ days	☐ # of pregnancies: _____	☐ Fibrocystic breasts
☐ Interval of time between cycles: _____	☐ C-section	☐ Breast cancer
☐ Any recent changes in normal menstrual flow (e.g. heavier, large clots, scanty)	☐ Date of last gynecological exam: ___/___/___	☐ Menopause
☐ Age of first period: _____	☐ Mammogram __(+) __(-)	☐ Surgical menopause
☐ Fibroids/ovarian cysts	☐ PAP smear __(+) __(-)	☐ Other: _____
☐ Vaginal infections	☐ Oral contraceptive	

Family history (parents and siblings)		
☐ Arthritis, rheumatoid	☐ Diabetes	☐ Neurological disorders
☐ Asthma	☐ Drug addiction	☐ Obesity
☐ Alcoholism	☐ Glaucoma	☐ Osteoporosis
☐ Alzheimer's disease	☐ Heart disease	☐ Stroke
☐ Cancer	☐ Mental illness	☐ Suicide
☐ Depression	☐ Migraine headaches	☐ Other: