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PATIENT INFORMATION SHEET

Important: Complete this form as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date	Full Name	Preferred Name/Nickname		
Gender M F	Date of Birth	Age	Marital Status Single Married Separated Divorced	
Address		City	State	Zip
Daytime Phone # (home, work, cell – circle one) ()		Alternate # (home, work, cell – circle one) ()		
Emergency Contact & Relationship		Phone Numbers of Emergency Contact Primary () Alternate ()		
Circle Health Insurance Coverage None PPO POS HMO Workers' Comp Auto Injury with MedPay Military Other _____				
Would you like to receive an appointment confirmation via email? Y N Would you like to receive a monthly email newsletter? Y N Would you like to be updated on clinic events via email? Y N <i>Please be assured that your email address will only be used by our office for the above intended purposes and will not be sold to other companies or individuals.</i> Email: _____				
Primary Care Doctor		Specialty		
Other Doctors You See		Specialty		
How did you hear about us?				
Cancellation Policy – I acknowledge that I will give at least 24 hour notice of cancellation to avoid a charge for the session. This is a courtesy to other patients who may need that appointment time. I will call if I anticipate being more than 15 minutes late for my appointment. Initials _____				
ASSIGNMENT, LIEN AND AUTHORIZATION INSURANCE BENEFITS AND ATTORNEY To Whom It May Concern: I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to ELIXIR				

CHIROPRACTIC & ACUPUNCTURE, P.C. such sums as may be due and owing this Office for services rendered me, both by reason of accident or illness, and by reason of any other bills that due this Office, and to withhold such sums from any disability benefits, medical payment benefits, No -Fault benefits, health and accident benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me, or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to said Office against any and all insurance benefits named herein, and any and all proceeds of settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided. In the event my insurance company obligated to make payments to me upon the charges made by this Office for their services, refuses to make such payments, upon demand by me or this Office, I hereby assign and transfer to this Office any all causes of action that I might have or that might exist in my favor against such company, and authorize this Office to prosecute said cause of action either in my name or in the Office's name, and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit. I understand that I remain personally responsible for the total amounts due the Office for their services. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option. I understand that for any reason my account is turned to collection, all the extra cost will be added to my balance and I am responsible for the payment.

Your fees are due and payable at the time examinations, X-rays, and treatments are received, unless other arrangements have been made in advance. X-rays remain property of this clinic.

I authorize the Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Office be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill. I, the undersigned, hereby give permission for treatment.

Patient's Signature _____ Social Security No.: _____

Date: _____ / _____ / _____

APPLICATION FOR TREATMENT

Please describe the principal health problems for which you came to this office. _____

How and when did symptoms first occur? _____

List any other doctors seen for these problems _____

List diagnosis(es) and type of treatment(s) _____

Does this interfere with your normal living and work? Yes ___ No ___ In what way? _____

Have you lost any days of work? Yes ___ No ___ Dates _____

Have you had similar symptoms or injuries before? Yes ___ No ___ If yes, explain _____

List the names of any relatives that have or have had a similar problem _____

Who is responsible for your bill? Self ___ Spouse ___ Employer ___ (Insurance ___ Name: _____
Other _____

How payment will be made: Cash ___ Worker's Compensation ___ Health Insurance ___
Check ___ Credit Card ___ Automobile Ins. Policy ___

Name of Company and Address _____

PAST HISTORY

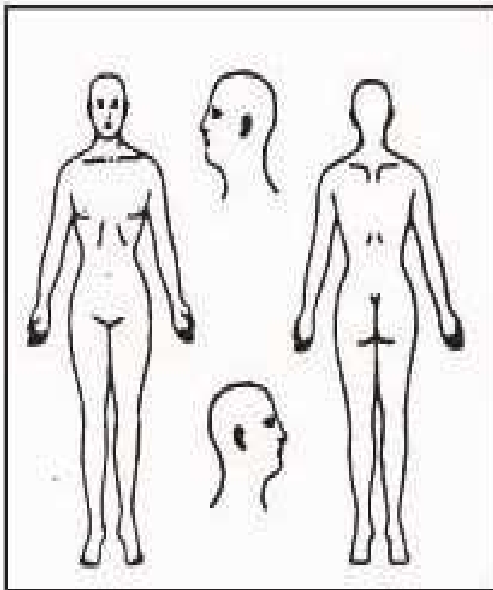
Has a physician treated you for any health condition in the last year? Yes ___ No ___

If yes, explain: _____

Have you or any relative received Chiropractic treatment previously? Yes ___ No ___ If yes, explain _____

Have you or any relative received Acupuncyure treatment previously? Yes ___ No ___ If yes, explain _____

Please mark your areas of pain on the figures below.



List the conditions that you are most interested in getting corrected. List in order of importance:

1. _____
2. _____
3. _____
4. _____

What functions are you unable to perform or induce pain upon performance?

List in order of severity. (Example: sitting, walking, bending, lying down, etc.)

1. _____
2. _____
3. _____
4. _____

Signature of Patient _____ Date: _____

General Pain Index Questionnaire

We would like to know how much your pain presently *prevents* you from doing what you would normally do. Regarding each category, please indicate the *overall* impact your present pain has on your life, not just when the pain is at its worst.

Please *circle the number* which best describes how your typical level of pain affects these six categories of activities.

1. **Family/at -home responsibilities** such as yard work, chores around the house or driving the kids to school -

0 1 2 3 4 5 6 7 8 9 10

completely able to function totally unable to function

2. **Recreation** including hobbies, sports or other leisure activities –

0 1 2 3 4 5 6 7 8 9 10

completely able to function totally unable to function

3. **Social activities** including parties, theater, concerts, dining –out and attending other social functions with friends -

0 1 2 3 4 5 6 7 8 9 10

completely able to function totally unable to function

4. **Employment** including volunteer work and homemaking tasks -

0 1 2 3 4 5 6 7 8 9 10

completely able to function totally unable to function

5. **Self -care** such as taking a shower, driving or getting dressed -

0 1 2 3 4 5 6 7 8 9 10

completely able to function totally unable to function

6. **Life -support activities** such as eating and sleeping -

0 1 2 3 4 5 6 7 8 9 10

completely able to function totally unable to function

Score _____ [60]

Benchmark -5 = _____

Patient _____ Date _____

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a "C" under appropriate person's column. "P" should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

Age	You	Father	Mother	Spouse	Brother(s)	Sister(s)	Children
Arthritis							
Asthma-Hay Fever							
Back Trouble							
Bursitis							
Cancer							
Constipation							
Diabetes							
Disc Problems							
Emotion Problems							
Emphysema							
Epilepsy							
Headaches							
Heart Trouble							
High Blood Pressure							
Insomnia							
Kidney Trouble							
Liver Trouble							
Migraine							
Nervousness							
Neuritis							
Obesity							
Pinched Nerves							
Scoliosis							
Sinus Trouble							
Stomach Trouble							
Other:							

If any of the above family members are deceased, please list their age at death and cause.

List any surgeries you have had and year it was performed.

TRAVEL: Have you ever traveled or lived outside the U.S.? Yes No
 Any health problems when abroad? Yes No If yes, what? _____

FEMALES:

Form of birth control _____	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Clotting	<input type="checkbox"/> Hot flashes
Last period _____	Last PAP test _____	<input type="checkbox"/> Heavy bleeding	<input type="checkbox"/> Vaginal dryness
Age started menstrual cycle _____	Age stopped _____	<input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Menstrual pain	<input type="checkbox"/> Water retention	No. Pregnancies _____	_____
<input type="checkbox"/> Low backache	<input type="checkbox"/> Mood changes	No. Vaginal Deliveries _____	No. Miscarriages _____
<input type="checkbox"/> Irregular	<input type="checkbox"/> Painful breast	No. Caesareans _____	No. Abortions _____

MEDICAL CONDITIONS - Please list conditions & surgeries you have or have had and year diagnosed.		ALLERGIES Medications, Seasonal, Environmental, Food	OCCUPATIONAL CONCERNS Check (✓) if your work exposes you to the following.
Year	Condition/Surgery		Occupation:
			<input type="checkbox"/> Stress
			<input type="checkbox"/> Heavy Typing/Computer Use
			<input type="checkbox"/> Hazardous Substances
			<input type="checkbox"/> Heavy Lifting
			<input type="checkbox"/> Other

MEDICATIONS - Please list all prescription medication you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose drops.

Prescription name	Purpose	How long	Dose	How often	Last Dose

SYMPTOMS - For each symptom you currently have, rate its severity from 1-5 (5 being the worst). Leave blank if N/A.

<p>LIVER/GALLBLADDER</p> <p><input type="checkbox"/> Irritability</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Headaches/migraines</p> <p><input type="checkbox"/> Visual problems</p> <p><input type="checkbox"/> Red eyes</p> <p><input type="checkbox"/> Dry/itchy eyes</p> <p><input type="checkbox"/> Spots in front of eyes</p> <p><input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Feeling of lump in throat</p> <p><input type="checkbox"/> Clenching of teeth at night</p> <p><input type="checkbox"/> Muscle cramping</p> <p><input type="checkbox"/> Muscle twitching</p> <p><input type="checkbox"/> Joints feel tight/stiff</p> <p><input type="checkbox"/> Cold hands/feet</p> <p><input type="checkbox"/> Soft/brittle nails</p> <p><input type="checkbox"/> Craving/avoiding sour foods</p> <p>KIDNEY/URINARY BLADDER</p> <p><input type="checkbox"/> Urinary problems</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Incontinence</p> <p><input type="checkbox"/> Weakness/pain in lower back</p> <p><input type="checkbox"/> Aching bones</p> <p><input type="checkbox"/> Feel cold easily</p> <p><input type="checkbox"/> Low sexual energy</p> <p><input type="checkbox"/> Excess sexual desire</p> <p><input type="checkbox"/> Poor memory</p> <p><input type="checkbox"/> Loss of hair</p> <p><input type="checkbox"/> Hearing problems</p> <p><input type="checkbox"/> Ringing in ears</p> <p><input type="checkbox"/> Craving/avoiding salty food</p>	<p>HEART/SMALL INTESTINE</p> <p><input type="checkbox"/> Heart palpitations</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Insomnia</p> <p><input type="checkbox"/> Easily startled</p> <p><input type="checkbox"/> Restlessness/agitation</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Breathlessness</p> <p><input type="checkbox"/> Vivid dreams</p> <p><input type="checkbox"/> Dreams are bothersome</p> <p><input type="checkbox"/> Lack of joy in life</p> <p><input type="checkbox"/> Laughing for no reason</p> <p><input type="checkbox"/> Craving/avoiding bitter foods</p> <p>LUNG/LARGE INTESTINE</p> <p><input type="checkbox"/> Dry cough</p> <p><input type="checkbox"/> Cough with sputum</p> <p><input type="checkbox"/> Nasal discharge</p> <p><input type="checkbox"/> Poor sense of smell</p> <p><input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> Itchy, red or painful throat</p> <p><input type="checkbox"/> Dry mouth</p> <p><input type="checkbox"/> Skin rashes</p> <p><input type="checkbox"/> Itchy skin</p> <p><input type="checkbox"/> Grief, sadness</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Low resistance to colds or flu</p> <p><input type="checkbox"/> Low physical stamina</p> <p><input type="checkbox"/> Mild fever comes and goes</p> <p><input type="checkbox"/> Craving/avoiding spicy foods</p>	<p>SPLEEN/STOMACH</p> <p><input type="checkbox"/> Heaviness anywhere in body</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Hard to get up in the morning</p> <p><input type="checkbox"/> Edema (swelling)</p> <p><input type="checkbox"/> Muscles feel tired often</p> <p><input type="checkbox"/> Easy bruising and bleeding</p> <p><input type="checkbox"/> Bad breath</p> <p><input type="checkbox"/> Low appetite</p> <p><input type="checkbox"/> Snacking</p> <p><input type="checkbox"/> Tendency towards hypoglycemia</p> <p><input type="checkbox"/> Difficulty digesting oily foods</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Gas/belching</p> <p><input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Indigestion/heartburn</p> <p><input type="checkbox"/> Over-thinking</p> <p><input type="checkbox"/> Tendency to become obsessive</p> <p><input type="checkbox"/> Craving/avoiding sweets</p>
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Healthy Living Questionnaire

Patient Name: _____ Date: _____

Age: _____ Gender: Male Female

Current Weight: _____

Do you consider yourself:

underweight overweight just right

Unintentional weight loss or gain of 10 pounds or more in the last three months: Yes No

Recent changes in your ability to:

see hear taste

smell feel hot/cold sensations

1. Check the Following Statements That Apply:

- Occasionally or frequently skip meals
- Suffer from fatigue
- Currently overweight
- Crave sweets or carbohydrates
- Crave stimulants, such as caffeine or soft drinks
- Suffer from chronic pain
- Suffer from headaches

2a. Activity Level – Check Your Current Level of Work or Lifestyle:

- Level 1 – Very Light Work:** Sitting, standing, driving, reading, computer, etc.
- Level 2 – Light Work:** Light housework, labor, childcare, mechanic, some sitting, etc.
- Level 3 – Moderate Work:** Heavy gardening, housework, labor, no sitting, etc.
- Level 4 – Heavy Work:** Heavy manual labor, construction, digging, etc.

2b. Exercise Level – Check Your Current Level of Exercise:

- None
- Level A – Light Exercise:** 1-3 times per week, easy pace, stretching, walking, etc.
- Level B – Moderate Exercise:** 2-3 times per week, moderate pace, some weights, etc.
- Level C – Heavy Exercise:** 3-4 times per week, vigorous pace, weights, fast running, etc.

3. Balance Eating – Check Which Apply:

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt Restriction
- Fat Restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions of:
 - dairy wheat eggs
 - soy corn all gluten
- Other _____

Servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

4. Eating Frequency – Check Which Apply:

- Skip breakfast or other meals _____
- Three meals/day
- Two meals/day
- One meal/day
- Graze-small frequent meals (how many/day) _____
- Generally eat on the run

5. Exercise Frequency and Schedule – Check Which Apply:

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 min or more duration per workout
- 30-45 min or more duration per workout
- Less than 30 min
- Use of personal trainer
- Member of fitness club
- Own exercise equipment
- Walk: days/week _____
- Run, jog, jump rope, other aerobic: days/week _____
- Weight lift: days/week _____
- Stretch: days/week _____
- Yoga: days/week _____
- Other _____ days/week _____

Healthy Living Questionnaire~Page 2

6. Stimulant Use Habits – Check Which Apply:

- Tobacco:
 - Cigarettes: #/day _____
 - Cigars: #/day _____
 - Pipe: #/day _____
- Alcohol:
 - Wine: # glasses/day or week _____
 - Liquor: # ounces/day or week _____
 - Beer: # glasses/day or week _____
- Caffeine:
 - Coffee: # of 6 oz cups/day _____
 - Tea: # of 6 oz cups/day _____
 - Soda w/caffeine: # of cans/day _____
 - Soda w/o caffeine: # of cans/day _____
 - Other sources _____
- Water:
 - # glasses/day _____

9. Energy – Vitality

- I'd like to:
- Have more energy
 - Have longer endurance
 - Have more motivation
 - Sleep better
 - Be less tired after lunch
 - Feel more vital
 - Regain vitality and vigor of my younger years
 - Get less colds and flu
 - Get rid of allergies
 - Not use so many over the counter drugs
 - Stop using laxatives
 - Be free of pain

7. Stress Habits – Check Which Apply:

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Is your job associated with potentially harmful chemicals, pesticides, radioactivity or solvents? Y N

Do you suffer from insomnia/sleep disorders? Y N

Do you often abruptly awake from sleep? Y N

Do you suffer from depression/mood swings? Y N

10. Longevity – Life Enrichment

- I'd like to:
- Reduce my risk of degenerative disease
 - Slow down accelerated aging
 - Monitor biomarkers of aging
 - Have less facial wrinkles
 - Maintain a healthier life longer
 - Change from a "treating-illness" orientation to a creating wellness lifestyle

8. Supplement Use Habits – Check Which Apply:

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- GLA (Evening primrose)
- Calcium, source _____
- Magnesium
- Zinc
- Minerals, describe _____
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (lutein, resveritol, etc.)
- Herbs – teas
- Herbs – extracts
- Chinese herbs
- Ayurvedic herbs
- Homeopathy
- Bach flowers
- Superfoods (bee pollen, phytonutrient blends)
- Liquid meals (Ensure)
- Other _____

11. Body Composition – Fat/Muscle

- I'd like to:
- Be stronger
 - Be thinner
 - Be more muscular
 - Burn more body fat
 - Be more flexible
 - Lose weight

12. Stress Reduction – Mental/Emotional

- I'd like to:
- Be happier
 - Be less depressed
 - Be less moody
 - Be less indecisive
 - Be more focused
 - Think more clearly
 - Improve my memory
 - Learn how to reduce stress
 - Learn how to meditate

COMMENTS

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INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at this office or any other office or clinic, whether signatories to this form or not.

I understand the methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the office medical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name _____

Patient's Signature _____

Date Signed _____

Name of Acupuncturist: Dr. Mooness Talebnia D.C., M.S., Board Certified Acupuncturist