



Elixir Wellness Centre

Dr. Frank Antikidis D.C.
Dr. Monica Talebnia D.C., M.S.

www.ElixirWellnessCentre.com
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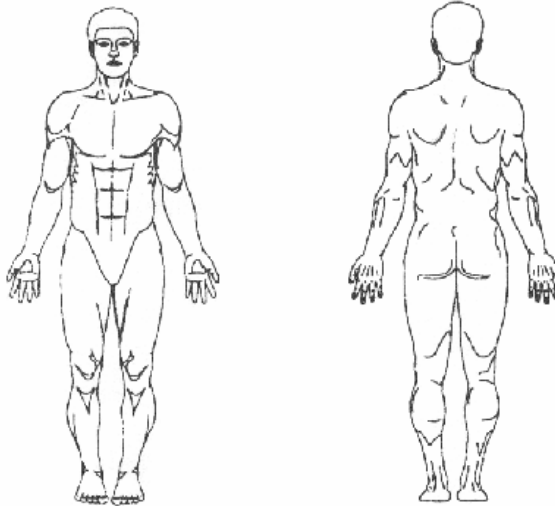
505 North Lake Shore Dr.
Suite 210
Chicago, IL 60611
312/245-2500 (phone)

Patient Intake Form

Note: Information provided on this form is confidential
It is very important that the information given is complete and accurate to assist you properly in your healing process.

Please PRINT Today's Date ___/___/___
How did you hear about us?
Name Date of Birth Age Sex: Male Female
Address
City/ State/ Zip
Telephone (home) (work) (cell)
Email Address
Occupation
Emergency Contact Person / Relationship Tel:
Physician Physician's phone #
Which procedure are you interested in?
Elixir Acu-lift(face) Elixir Acu-thin(weight loss) Elixir Acu-smooth(cellulite)
Elixir Acu-fertile(fertility) Elixir Acu-balance(women's health)
Any specific areas that needs to be addressed?
How long have you had this condition?
The onset was: sudden gradual
Symptoms relieved by Symptoms worsened by
What medical diagnosis have you received for this condition?
What other treatments have you received for this condition?
What medications are you taking?
For what condition(s)?
Is this your first experience in Oriental Medicine and acupuncture?
How do you feel about acupuncture?
Are you currently pregnant? Yes No
Are you presently trying to get pregnant? Yes No

On the following drawings, shade in the areas where you feel should be addressed.



Past Medical History:

Have you had any of this condition(s)? Check all that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies (food, latex) | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herpes | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Birth Trauma | <input type="checkbox"/> Joint Replacements | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lyme’s Disease | <input type="checkbox"/> Sinus Infections |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lymph Nodes removed | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Drug Addictions | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Operations _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other _____ |

Family Medical History: (Please list any significant family illnesses, e.g. diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders, arthritis)

Mother: _____
Father: _____
Siblings: _____
Grandparents: _____

Facial Cosmetic Acupuncture:

Are you interested in facial cosmetic acupuncture? Yes No
Are you a candidate for a facial cosmetic acupuncture? Check which of the following applies to you:
Migraines Seizure Disorders Uncontrolled HTN Blood Thinning Drugs High Stress Pregnancy
(If you checked any of the previous boxes, please see your practitioner.)
What area of the face do you feel needs improvement? Forehead Eye Area Cheeks Neck Lips

Exercise & Energy:

How is your energy? Low Up & Down Exhausted Hyperactive Nervous Energy Abundant
What time of day is your energy: Highest? _____ Lowest? _____

Do you fatigue easily? _____
What kind of exercise do you do? _____
How often do you exercise? _____

Next page

Emotions & Sleep:

How do you feel emotionally? _____
Do you have (check all that apply): Panic attacks Depression Anxiety Bad temper Nervousness
Fear attacks Poor memory Difficult concentration Sadness Sensitive Worries Over-Excited Angry
Are you in a relationship? Yes No
How do you feel about your relationship? _____
How do you hold stress? _____
How do you relax? _____
How do you feel about your work? _____

Sleep pattern:

How long do you normally sleep? _____ hours per night
I have difficulties with (check all that apply): Falling asleep Staying asleep Dream-disturbed sleep
Falling Asleep: Sometimes difficult Sometimes very difficult Sleepy in daytime Always difficult
Always very difficult Take naps
Waking Up: at about _____ am/pm and not being able to fall asleep again
Sleep Quality: Deep Light Bad Many Dreams Bad Dreams Grinding Teeth
Talking in sleep Other

Gastrointestinal:

I have (check all that apply): Belching Nausea Vomiting Vomiting of blood Ulcers Rapid Hungering
Poor Appetite Anorexia Bloating Acid regurgitation Heartburn Hernia
Indigestion Severe stomach pain
Bowel movements: How often? _____ time(s)/day _____ days/week
I have (check all that apply): Irregular Constipation Diarrhea Gas Burning sensation
Hemorrhoids Undigested food in stool Loose stool Watery stool Incomplete stool Hard stool
Strong smell With mucus Blood in stool Itchiness Painful bowel movements

Urinary:

Urination: How often? _____ times per day. Color: Pale yellow Dark yellow/orange
Number of times per night _____
I have or had (check all that apply): Trouble starting stream Frequent urination Incontinence Retention Pain
Burning Dark Color Foul smell Urgent Cloudy Difficulty Dribbling when sneezing Blood in urine
Kidney stones Urinary tract infections
Other _____

Women:

At what age did you start menstruating? _____ Date of your last period __/__/__
Number of days between cycles: _____
Number of days of flow: _____
Color: Pale red Dark red Bright red Purplish
I have or had (check all that apply): Irregular menstruation Heavy flow Light flow No flow Clots
Menstrual pain: Before flow During flow After flow Abdomen Back Breast
Emotion around period: Before flow During flow After flow Depression Irritability Anger Sadness
Vaginal itching/burning Spotting between periods Discomfort/pain before period Discomfort/pain during period
Other _____
Any vaginal discharge? No Yes Color _____

Men:

I have (check all that apply): Prostatitis Impotence Penis blood/mucous discharge
Other: _____

Muscles, Joints & Bones:

Do you have pain or tightness? No Yes Where? _____
The pain is (check all that apply): Sharp Dull Aching Numb Superficial Pain Deep Pain
Burning Tingling Shooting Pain worse/better with heat Pain worse/better with cold
Pain worse/better with pressure Pain worse in am/pm
I have (check all that apply): Swollen joints Arthritis/joint pain Tendonitis Bone pain Muscle cramping
Muscle pain Repetitive Strain Injury Fractured Bone(s) Where? _____
Other _____

Eyes, Ears, Nose, Throat, & Head:

Do you smoke? No Yes _____ per day, for _____ years
I have (check all that apply): Frequent colds Chronic runny nose Frequent sore throat Chronic cough
Coughing blood Cough up mucous Pain inhaling Shortness of breath on exertion/at rest Asthma
Nose bleeds Painful/red eyes Poor vision See spots/floaters Dizziness Cold sores
Bleeding gums Dry mouth Ear pain Ringing in ears Clogged/popping in ears
Frequent headaches/migraines describe: _____

Cardiovascular:

I have (check all that apply): Chest pain Palpitation Varicose veins Phlebitis Cold hands and feet
Irregular heart beat Poor circulation Other: _____

Skin & Hair:

I have or often have (check all that apply): Dry skin Skin rashes Itching Acne Eczema Hives
Hair loss Premature graying Other: _____

Body Weight:

Overweight Underweight
If overweight:
How many pounds would you like to lose? _____
How many years ago did you first start to gain weight? _____
Are you following a weight control program at this time? _____

Sensitivity & Allergy:

Temperature: Cold Hot Dampness Light Noise Airborne particles Food Drugs Others

Body Temperature:

Feeling cold easily Cold hands Cold feet Alternating hot & cold Feel hot easily Hot flash
Sensitive to weather changes

Sweating:

Too easily Too much Difficult Too little Night sweats

Drinking:

Thirsty Dry mouth Drink a lot Dry mouth but no desire to drink
Not thirsty, but drink a lot of water anyway

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
Dr. Frank Antikidis B.S., D.C., Certified in Acupuncture