LARISSA POPOV, H.B.Sc., N.D.
DOCTOR OF NATUROPATHIC MEDICINE

Healing Hands *Family Chiropractic and Massage Centre*
923 Kingston Road, Toronto, ON M4E 1S6
Clinic Tel: 416-699-6336

Congratulations for taking the steps toward better health!

We practice naturopathic medicine and complimentary therapies and we endeavor to help you achieve your health goals in a caring, compassionate and supportive environment.

The Principles of Naturopathic Medicine:

First, do no harm.
Cooperate with the healing power of nature.
Address the fundamental cause of disease.
Heal the whole person through individualized treatment.
Teach the principles of healthy living and prevention.

<u>This package consists of 3 parts:</u>

- Fee Schedule (page 2)
- Informed Consent Form (pages 3, 4)
- New Client Intake Form (pages 5-10)

Please read all of the information provided, complete the **Intake Form** and **Informed Consent Form**, and **bring them with you on your first visit**. The information you provide will play an important role in developing your individualized health care plan. Please note: the information provided on these forms and in our interactions are strictly confidential.

Your first visit is 1 ½ hours long and will include:

- A thorough health history including review of your intake form
- Review of your current supplements and medications (please bring them with you)
- Review of any laboratory reports, blood tests, etc. (please bring copies of any lab reports conducted in the last 6 months)
- Physical examination, time permitting
- Some initial treatment recommendations, if applicable

The **second visit** typically includes a physical examination (excluding female gynecological exam) and after the necessary information has been gathered from the intake, physical examination and laboratory testing, a treatment plan will be presented. The frequency and duration of subsequent visits required to monitor your progress and to provide treatments will be determined based on the nature of the condition and the type of treatment plan.

We look forward to meeting you!

Sincerely,

Larissa Popov, N.D.

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FEE SCHEDULE

Naturopathic consultations:

Adults:		
Initial visit	90 minutes	$180
Follow-up visit	60 minutes	$120
	45 minutes	$90
	30 minutes	$60
Homeopathic Intake	120 minutes	$250
Phone consultation	15 minutes	$30
Bundles:		
Acupuncture:	8 x 30 minute visits	$400
Bodywork	4 x 60 minute visits	$360
Students & Seniors:		
Initial consult	90 minutes	$145
Follow-up visit	60 minutes	$ 100
	30 minutes	$ 50
Homeopathic Intake	120 minutes	$210
Phone consultation	15 minutes	$ 30
Children (age 17 and under):		
Initial consult	60-90 minutes	$140
Follow-up visit	45 minutes	$ 65
	30 minutes	$ 45
Homeopathic Intake	90-120 minutes	$ 180
Laboratory testing		
Dipstick Urinalysis		$ 6
Hair Mineral Analysis		$ 60

***All fees are subject to G.S.T.**
**** Fees are subject to change without notice.**

Payment policy:

Please note that fees are not covered by OHIP, but they are covered by many **extended health care plans**.
Payment may be made by **cash, cheque, debit or credit card** at the end of the appointment.
Cheques returned to the clinic by your bank for any reason will be subject to a $30 service fee.

Missed appointments:

Appointment times missed without a minimum of 24 hours notice are subject to a fee of $75.00.

Insurance:

If you or a family member carries extended health care benefits, please be aware of the limitations of your naturopathic coverage and the procedures for reimbursement. We require payment in full at the time of services rendered, however we will gladly provide the documentation necessary to submit your claim.
Most insurance plans *do not* cover the cost of supplements or other health products related to the treatment plan.

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INFORMED CONSENT

Naturopathic medicine is the treatment and prevention of disease by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

A number of different approaches may be used throughout the course of treatment. Treatment modalities include Diet, Lifestyle Counselling, Clinical Nutrition, Herbal Medicine, Homeopathy, Traditional Chinese Medicine and Acupuncture, Hydrotherapy, Physical Medicine and Bodywork.

Nutrition: Dietary modifications and/or supplementation are given in order to address deficiencies, treat disease processes, and to support proper functioning of the body.

Herbal medicine: Is a plant-based medicine that involves the use of herbs in the form of teas, tinctures, capsules, tablets, flower essences and topical preparations. Herbs can be used to assist in the recovery from illness or injury and support proper functioning of the body.

Homeopathy is a form of medicine based on the *Law of Similars*, or "like cures like. The *Law of Similars* states that a substance that can create symptoms in healthy people, at very minute doses, can be used to treat these same symptoms. These minute doses of plant, animal or mineral origin are powerful medicines that stimulate the body's natural ability to heal itself on the physical, mental, emotional and spiritual level.

Traditional Chinese Medicine is a system based on the Taoist philosophy of the balance between *Yin* and *Yang*, opposite poles in nature. Treatment strategies include the use of herbs, acupuncture and dietary modifications to bring the body back into balance. Herbs may be given in the form of tablets, tinctures, and decoctions (strong teas) to be taken internally or used externally. Acupuncture is performed only using single-use sterile needles.

Hydrotherapy is the therapeutic use of water. Hot and cold applications may be used to promote circulation, reduce inflammation and strengthen the immune system.

Physical Medicine includes basic soft-tissue work, orthopedic testing and assessments.

Lifestyle counselling involves identifying risk factors and making recommendations that will promote physical, mental, emotional and spiritual well-being.

Bodywork:
Craniosacral Technique is a type of gentle bodywork based on Osteopathic techniques that involves the subtle release of tissues and joints from restriction while working within the body's natural limitations.
Bowen Technique is a type of gentle bodywork which uses soft plucking motions at points along the muscles and tendons which release structures from their "holding patterns" and allow them to relax and rebalance with the rest of the body.
Both techniques ellicit a deep relaxation response in the recipient and can be very beneficial for a variety of conditions.

Laboratory testing: Your naturopathic doctor may collect urine, hair or other samples for in-office laboratory tests or refer you externally for lab testing as required.

Health risks associated with treatment by naturopathic medicine include but are not limited to:

- aggravation of pre-existing symptoms during the healing process
- allergic reactions to supplements or herbs
- pain, bruising or injury from acupuncture
- fainting or puncturing of an organ with acupuncture needles

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STATEMENT OF ACKNOWLEDGEMENT

I, (print your name) ________________________, acknowledge that as a client of the naturopathic doctor, I have read the information included herein, and I understand that the services provided are based on naturopathic medicine and other complimentary therapies. I also recognize that even the gentlest therapies may cause complications in certain physiological conditions which depends greatly on the individual and the extent of illness. Some therapies must be used with caution in cases such as diabetes, heart, liver or kidney disease, pregnancy, lactation, infants, elderly, or those on multiple medications. I therefore confirm that I have informed and will continue to inform my practitioner fully of my medical history, family history, medications and/or supplements I am currently taking (prescription or over-the-counter), or was previously taking. If I am female, I have advised my practitioner that I am pregnant or breast-feeding or that there is a possibility that I am pregnant, and I will continue to do so.

_____ Initials — I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

_____ Initials — I understand that the naturopathic doctor will answer any questions I have to the best of her ability. I understand that I will be informed of the diagnostic and therapeutic procedures and treatment plan before undergoing treatment and I will discuss any requests for related information with the naturopathic doctor. I acknowledge and confirm that I will become informed of the diagnostic and therapeutic procedures and plans with respect to financial costs, expected benefits, potential risks and side effects, the likely consequence of not having or following the treatment plan, and any alternative course(s) of action available to me. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge I voluntarily consent to the recommended diagnostic and therapeutic procedures outlined above, except for (please list any exceptions):____

_____ Initials — I understand that fees and dispensary purchases are not covered by OHIP and are to be paid in full at the end of the appointment.

_____ Initials — I understand that a fee may be charged for any missed appointments or cancellations with less than 24 hours notice.

_____ Initials — I understand that any treatment or recommendation provided to me by the Naturopathic Doctor is *not* mutually exclusive from any other treatment or recommendation that I may now be receiving or may in the future receive from another licensed health care provider. I am at liberty to seek or continue medical care from a medical doctor or other health care provider licensed to practice in Ontario.

_____ Initials — As part of my agreement to treatment with the naturopathic doctor, I will maintain annual physical exams with my family doctor as well as continue to receive medical treatment and supervision with a conventional medical doctor.

_____ Initials — I have read and understood the above stated policies and information. I intend this consent form to cover the entire course of treatment I receive with the naturopathic doctor. I understand that I am free to withdraw my consent and discontinue treatment at any time.

Client name (please print):____________________________________ Date: ____________________________

Signature: ____

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CONFIDENTIAL CLIENT INTAKE FORM

Personal information:

Name: ______________________________ Date: ______________________

Date of birth: ____________________ Age: ________ Sex: M F

Address: ______________________________ City: ____________ Postal code: ________

Phone (home): ________________________ Phone (work): ________________________

Phone (cell): ________________________ Email: ________________________

Occupation: ________________________ Employer/school: ________________________

Marital status: single common-law same-sex married separated divorced widowed

Living arrangements: myself w/spouse w/partner w/parents w/children w/friends

Emergency contact:

Name: ______________________________ Relationship: ______________________

Phone#: ________________________ Work phone#: ________________________

Other practitioners:

1. ______________________________ phone#: ______________________
2. ______________________________ phone#: ______________________
3. ______________________________ phone#: ______________________

Do you have extended healthcare insurance? ______________________________

When was your last physical exam with your medical doctor? ______________________________

Have you ever seen a Naturopathic Doctor before? Yes/No How long ago? ______________________

How did you hear about the clinic? ______________________

Please list in order of priority, your major health concerns including when they started and any known causes:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Please describe your overall state of health: ______________________________

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What prescription medications are you currently taking?

	Name & Amount	For What?	For How Long?
1.			
2.			
3.			
4.			
5.			

What medications have you taken in the past and for how long?

____

____

Number of antibiotic prescriptions in the last 10 years? ____________________

Have you ever taken the flu vaccine? Yes/No Date of most recent flu vaccine:__________

Have you ever experienced adverse reactions to vaccination in the past? Yes/No

Explain: ____

What supplements are you currently taking?

	Name & Amount	Reason	For How Long?
1.			
2.			
3.			
4.			
5.			

Do you take OTC (over the counter) medications (Pain relievers, cortisone cream, laxatives, antacids, etc.) Yes/ No

Which ones?____

What for? ____

PERSONAL HEALTH HABITS:

Height: _______ Current weight: ______ Weight 1 year ago: ______Ideal weight: ______

Regular Exercise: Yes/No Type: __________ Duration: ________ How often:________

Water: ________ glasses/day Purified water: Yes/No Tap water: Yes/No

Coffee: Yes/No _________ cups/day Tea: Yes/No _________cups/day

Cigarettes/Tobacco: Yes/No Smoked _____ years Amount/day:______ Year stopped_____

Alcohol use: Yes/No Type: ______________ Amount per week:________________

Recreational drug use: Yes/Past/No Type: ____________ How often? ____________

Are there any food groups you avoid? Yes/No ______________________________

Are there any food groups you eat lots of? Yes/No ______________________________

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FAMILY MEDICAL HISTORY: Please indicate where applicable:

	Age	Medical conditions
Father	______	______________________________
Mother	______	______________________________
Siblings	______	______________________________
	______	______________________________
	______	______________________________
Maternal grandmother	______	______________________________
Maternal grandfather	______	______________________________
Paternal grandmother	______	______________________________
Paternal grandmother	______	______________________________

Possible medical conditions: allergies, arthritis, asthma, eating disorder, epilepsy, heart disease, high blood pressure, stroke, cancer, diabetes, depression, substance abuse, mental illness, bleeding problems, multiple sclerosis, obesity, kidney disease, tuberculosis, thyroid problems, other

PAST MEDICAL HISTORY

Injuries/Traumatic events:

1.______________________________ Year ____________
2. ______________________________ Year ____________
3. ______________________________ Year ____________

Major Ilnesses:

1.______________________________ Year ____________
2. ______________________________ Year ____________
3. ______________________________ Year ____________
4. ______________________________ Year ____________

Surgeries/Hospitalizations:

1.______________________________ When diagnosed____________
2. ______________________________ When diagnosed____________
3. ______________________________ When diagnosed____________

Allergies/Food intolerances:

1.______________________________ When diagnosed ____________
2. ______________________________ When diagnosed____________
3. ______________________________ When diagnosed____________

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ENERGY: On a scale of 1-10, how would you rate your energy level? ___ (0= no energy, 10 = your highest ever)

When during the day is your energy the highest? ____________ The lowest? ____________

PERSPIRATION: Do you perspire easily? Yes/No Where on the body do you perspire? ____________________________

SEXUAL HEALTH: How would you rate your libido on a scale of 1-10? ________________ (0 = lowest, 10 = highest)

Are you currently sexually active? Yes/No

Any concerns related to sex-drive, sexual health? ____

Method(s) of contraception used: ____

SLEEP: How many hours of sleep do you get per night? _____ Do you wake feeling rested? Yes/No

Do you have trouble falling asleep: Yes/No

Do you have trouble staying asleep: Yes/No

If so, how many times do you wake up per night? ________________

If you get up, how long does it take to fall asleep again? ____

Are there any factors interfering with your sleep? Yes/No ____

MOOD: How would you describe your mood generally? ____

Are you concerned about your mood? Yes/No

Which of the following moods do you tend to experience? (please circle all that apply)

Grief/sadness anger/frustration lack of joy fear/anxiety worry/over-thinking happiness/contentment

Which ones do you tend to experience often? ____

STRESS: On a scale of 1-10, how would you rate your stress level? ____________ (0= no stress, 10= your highest ever)

What are your main sources of stress: ____

Please list the 5 most significant stressful events in your life from most recent to most distant.
Are you aware of any of these continuing to impact your life?

1. ____
2. ____
3. ____
4. ____
5. ____

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BOWEL MOVEMENTS: How many bowel movements are you having each day? ______

Do you experience any difficulty in passing a bowel movement? Yes/No

Do you take anything to assist your bowels in moving regularly? Yes/No What do you take? ______________

Have you noticed any blood, mucus or undigested food in your stool? Yes/No

If yes, please explain ____

FOR WOMEN:

What was the date of your last menstrual cycle? _______________________

How long is your menstrual cycle; time from one menses to the next? ________days

How long does your flow last? _____

At its heaviest, how many pads/tampons do you use in a day? _______ When is it heaviest? ___________________

At its lightest, how many pads/tampons do you use in a day? ________ When is it lightest? ____________________

Describe colour of flow (bright red, dark red, brown, etc): ____

Please circle any of the following menstrual symptoms you experience:

Cramping	breast tenderness	irritability	swelling	loose stool
Clots	bloating	weepiness	constipation	lower back pain
Heavy flow	Scanty flow	fatigue		

Any concerns with discharge? (colour, smell, amount) ____

Date of last gynecological exam and pap smear: ___________________________________

Are you currently pregnant? Yes/ No /Not sure

Type of birth control used: __________ If birth control pill used, how many years? ______ Date ended: _______

Please complete the Review of Systems on the next page.

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REVIEW OF SYSTEMS

Please indicate any that apply to you: Check current conditions with a "Y" and past conditions with a "P"

__ Pneumonia
__ Rheumatic fever
__ Polio
__ Tuberculosis
__ Whooping cough
__ Anemia
__ Measles
__ Stroke

__ Mumps
__ Small Pox
__ Chicken pox
__ Diabetes
__ Cancer
__ Heart disease
__ Thyroid disorders
__ Head injury

__ Influenza
__ Pleurisy
__ Hepatitis
__ Epilepsy
__ Mental Illness
__ Eczema/Psoriasis
__HIV positive/AIDS

Ears/Eyes/Nose/Throat
__ Vision problems
__ Dental problems
__ Sore throat
__ Earaches
__ Hearing difficulty
__ Stuffed nose
__ Sinus problems

Respiratory
__ Lung problems
__ Lung congestion
__ Shortness of breath

Digestive System
__ Poor appetite
__ Excessive appetite
__ Excessive thirst
__ Nausea
__ Vomiting
__ Diarrhea
__ Constipation
__ Hemorrhoids
__ Liver problems
__ Gallbladder problems
__ Weight problems
__ Abdominal cramps
__ Gas/bloating after meals
__ Black stools
__ Bloody stools
__ Heartburn
__ Colitis
__ Gallstones

Muskuloskeletal
__ Low back pain
__ Pain (where)________
__ Joint pain
__ Joint stiffness
__ Difficulties walking
__ Difficulties chewing
__ Clicking jaw
__ General stiffness

Nervous System
__ Nervousness
__ Headaches
__ Numbness
__ Tingling extremities
__ Stress
__ Dizziness
__ Forgetfulness
__ Confusion
__ Depression
__ Fainting
__ Convulsions
__ Other _______

Cardiovascular/ Peripheral Vascular
__ Blood pressure problems
__ Irregular heartbeat
__ Heart problems
__ Varicose veins
__ Leg/ankle swelling
__ Cold extremities
__ Other ___________

Genito-urinary
__ Bladder problems
__ Painful urination
__ Excessive urination
__ Kidney stones
__ Kidney infections

Female
__Vaginal pain
__ Vaginal infection
__ Breast pain
__ Breats lumps
__ Breast implants
__ Sexual concerns
__ Menstrual irregularities
__ Menstrual cramping

Male
__ Prostate disorders
__ Sexual concerns
__ Decreased sex drive

Blood/Lymphatics
__ Bruise easily
__ Blood clotting problems

General
__ Fatigue
__ Seasonal Allergies

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*Thank you for taking the time to fill out the requested information.
It will be very helpful in assessing your present health
and in creating a personalized treatment plan
to help you work towards your health goals.*