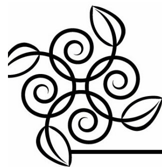

LARISSA POPOV, H.B.Sc., N.D.
DOCTOR OF NATUROPATHIC MEDICINE

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Clinic Tel: 416-699-6336

ACUPUNCTURE/BODYWORK TREATMENT PACKAGE

This package consists of 2 parts:

- Informed Consent Form & Fee Schedule (pages 2-4)
- New Client Intake Form (pages 5-9)

Please read all of the information provided, complete the **Intake Form** and **Informed Consent Form**, and **bring them with you on your first visit.** Please note: the information provided on these forms and in our interactions are strictly confidential.

This intake form is for people who desire acupuncture or bodywork treatments alone, as opposed to a comprehensive treatment plan including acupuncture, homeopathy, nutrition, herbal medicine, lifestyle counseling and naturopathic treatment offered by the N.D.

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

- A thorough health history including review of your intake form
- Physical examination
- Initial Acupuncture treatment or 30 minute bodywork session

Subsequent acupuncture visits are 30-45 minutes in length. Subsequent bodywork sessions may vary from 30-60 minutes depending on circumstances.

A course of treatments for acupuncture is typically a minimum of 5-6 consecutive sessions. Ideally, the first 2 acupunctures occur in the first week of treatment, and then the following treatments occur once/week. A minimum course of treatment for bodywork is 4 sessions, once/week.

Cosmetic Acupuncture: Initial consults are 2 hours in length and includes facial massage and acupressure, skin topical treatments, and acupuncture for the face and body. Self-care maintenance techniques and tips will be offered over the course of treatment. For anti-aging programs, a minimum of 10 weekly sessions is required. For cellulite treatment, 4 sessions is required. From then onwards, “tune-up” appointments may be scheduled every 3-6 months.

We look forward to meeting you!

Sincerely,

Larissa Popov, N.D.

POLICIES and PROCEDURES:

Payment:

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 worth the cost of the visit**.

Insurance:

If you or a family member carries extended health care benefits, please be aware of the terms 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.

FEE SCHEDULE (fees are HST exempt) **as of February 2015

Service	Duration	Fee
Initial visit & first treatment (1st treatment: single acupuncture or 30 minute bodywork)	90 minutes	$200
Single acupuncture	30-45 minutes	$70
Acupuncture & Bodywork combo	60 minutes	$90
Bodywork (Bowen or Craniosacral)		
	30 minutes	$55
	45 minutes	$80
	60 minutes	$105
Initital Intake & 1st Cosmetic Acupuncture	120 minutes	$250
Single cosmetic acupuncture	60 minutes	$130

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. Naturopathic doctors have a minimum of 500 hours of trainining in Traditional Chinese Medicine & Acupuncture theory and practice.

Acupuncture: Based on the Taoist philosophy of the balance between *Yin* and *Yang*, opposite poles in nature. Points are chosen according to the client's symptoms as well as their unique constitution and organ-system imbalances. By using the needles to tap into the rivers of "qi" flowing through the body, we can strengthen or sedate these imbalances, brining the body into harmony, and reducing inflammation and pain. Acupuncture is performed only using single-use sterile needles.

Please notify the practitioner if you:

- Are pregnant
- Have a pacemaker or other embedded device
- Have a history of seizures

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 elicit a deep relaxation response in the recipient and can be very beneficial for a variety of conditions.

Benefits of Bowen and Craniosacral techniques: (not a complete list)

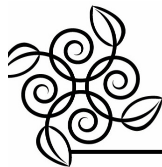
- Deep relaxation
- Breaking down scar tissue
- Releasing "holding patterns"
- Increased range of motion
- Improved digestion and elimination
- Reduce inflammation: sprains & strains
- Improve focus and mood
- Improve quality of sleep

Health risks associated with acupuncture include but are not limited to:

- aggravation of pre-existing symptoms during the healing process
- allergic reactions to topical creams, if used
- pain, bruising or injury from acupuncture
- fainting or puncturing of an organ with acupuncture needle

Possible contraindications for Bodywork: (If you fill any of these criteria, please discuss your circumstances with the practitioner before your first treatment.)

- medically-induced pregnancy
- recent stroke
- recent head injury
- post cataract surgery
- brainstem tumor
- cranio-vascular problems within the last 2 months



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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.

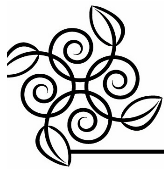
______ Initials — As part of my agreement to treatment with the naturopathic doctor, I will maintain annual physical exams with my family doctor as well as continue to receive medical treatment and supervision with a conventional medical doctor.

______ Initials — I understand that by choosing to work exclusively with acupuncture or bodywork treatments I am opting to not incorporate any adjunctive naturopathic care such as homeopathic or herbal medicines or nutritional and lifestyle recommendations. However, should I be interested in adding these therapies in the future, I can discuss this with the N.D. and switch to the regular naturopathic fee schedule and fulfill any additional visit time required to gain information needed for these treatments.

______ 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 ACUPUNCTURE/BODYWORK 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 married separated divorced widowed

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

Emergency contact:

Name:_____________________________ Relationship:____________ Phone#(s): _____________________________

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.____

What prescription medications are you currently taking?

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

What supplements are you currently taking?

Name, Brand & Dose	For What?	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 ____

FAMILY MEDICAL HISTORY: Please indicate where applicable:

	Age	Medical Conditions
Father		
Mother		
Siblings		

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

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PAST MEDICAL HISTORY

Injuries/Traumatic events:	Year
1.	
2.	
3.	

Major Illnesses, surgeries, hospitalizations (from childhood to present):	Year
1.	
2.	
3.	
4.	

Allergies/Food Intolerances (from childhood to present):	When diagnosed
1.	
2.	
3.	
4.	

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? ________________

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 wake up, how long does it take to fall asleep again?

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

MOOD: Which of the following moods do you tend to experience? (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? ____

BOWEL MOVEMENTS: Number of bowel movements each day? ______ Difficulty in passing a BM? 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 ______________________

DIGESTION: (circle all that apply) gas & bloating burping passing gas indigestion heartburn

GENERAL: Temperature: I tend to be chilly/warm. (circle one)

When drinking water I prefer it to be (circle one): ice cold cold room temp warm hot

Perspiration: Do you perspire easily? Yes/No Where on the body do you perspire? ________________

What type of weather bothers you (circle any that apply): Damp/Humid Hot/Dry Cold

Cravings (circle any that apply):

salty spicy deep fried farinaceous(pasta, bread) sweet sour creamy/rich other:________

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? ______

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

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? ____________

Please circle any of the following menstrual symptoms you experience (or have experienced in the past):
Please circle all that apply:

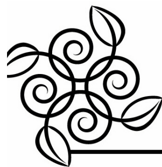
Cramping	breast tenderness	irritability	swelling	loose stool
Clots	bloating	weepiness	constipation	lower back pain
Heavy flow	Scanty flow	fatigue		

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