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

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

Dear Parent or Guardian,

Investing in your teen's health will benefit them now and for a lifetime! We practice naturopathic medicine and complimentary therapies and we endeavor to help your child achieve health in the most caring and gentle way as well as enable them to develop healthy habits for life.

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.

This package consists of 2 parts:

- Informed Consent Form (pages 2-4)
- 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 child's individualized health care plan. Please note: the information provided on these forms and in our interactions are strictly confidential.

Your teen's first visit is 1.5 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 consists of a physical examination and subsequent treatment recommendations. The frequency and duration of subsequent visits required to monitor your child's 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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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 worth the cost of the visit or an amount determined at the practitioner's discretion.

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.

Phone/email consults: Phone and email are important ways of keeping in touch, however the following are guidelines for appropriate use of phone & email with the naturopathic doctor, and when to expect fees for services delivered in this way.

No fee:
- Clarification regarding an existing treatment plan
- Sending a health status update that does not require further action
- Arranging appointment times

Fee charged:
- Client requests additional information, resources or recommendations beyond what was given in the last visit
- Acute or emergency situation where the client requests guidance or treatment to address the immediate concern
- The client discloses new information regarding their case which requires further investigation and possible changes 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 treatment approaches may be used alone or simultaneously throughout the course of treatment.

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. Acupressure or acupuncture may be made administered depending on the comfort level of the child.

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 in children 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 name of parent or guardian) _____, acknowledge that as the parent or guardian of

(Name of child) _____, I have read the information included herein regarding naturopathic care for my child, 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 with conditions such as diabetes, heart, liver or kidney disease, or those on multiple medications. I therefore confirm that I have informed and will continue to inform the practitioner fully of my child's medical history, family history, medications and/or supplements currently taken (prescription or over-the-counter), or was previously taking. If my child is female, I have advised the practitioner if my child is pregnant or breast-feeding or that there is a possibility that she is pregnant, and I will continue to do so.

_____ Initials
I understand that a record will be kept of the health services provided to my child. 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 child's medical record at any time and I 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 for my child 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 my child. 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 for my child, 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 for my child by the naturopathic doctor is *not* mutually exclusive from any other treatment or recommendation that he or she is now receiving or may in the future receive from another licensed health care provider. I am at liberty to seek or continue medical care for my child 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, my child will maintain annual physical exams with the 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 my child receives with the naturopathic doctor. I understand that I am free to withdraw my consent and discontinue my child's treatment at any time.

Name of Parent or Guardian (please print):_____Date: _____

Signature of Parent or Guardian:_____

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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: _____

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, 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 _____

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FAMILY MEDICAL HISTORY: Please indicate where applicable:

	Age	Medical Conditions
Father		
Mother		
Siblings		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

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:	Year
1.	
2.	
3.	

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

Surgeries/Hospitalizations (from childhood to present):	Year
1.	
2.	
3.	
4.	

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

Birth Details: Delivery: vaginal or cesarian (circle one)
Any complications, or significant details regarding mother's health during pregnancy and delivery?
_____

Childhood Illnesses: _____

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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? _____

SEXUAL HEALTH: Are you currently sexually active? Yes/No Any concerns related to 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? (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: _____
List any significant stressful events in your life. Do any of them continue to impact your health now?

_____

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

Difficulty in passing a bowel movement? Yes/No Take anything to assist your BMs? Yes/No

What do you take? _____ Noticed any blood, mucus or undigested food in your stool? Yes/No

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 creamy/rich sour other:_____

Birth details: Any notable events or complications during labour or at birth? Cesarian or vaginal?

_____

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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