



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.

This package consists of 3 parts:

- 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.



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
Bodywork	4 x 45 minute visits	\$320

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	\$130-140
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 H.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 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.



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 elicit 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



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.

_____ I understand that a record will be kept of the health services provided to me. This record
Initials 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.

_____ I understand that the naturopathic doctor will answer any questions I have to the best
Initials 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): _____

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

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

_____ I understand that any treatment or recommendation provided to me by the Naturopathic Doctor is *not*
Initials 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.

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

_____ I have read and understood the above stated policies and information. I intend this consent form to cover
Initials 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: _____



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: _____



Continued from page 5,

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 _____



Continued from page 6,

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:

1. _____ Year _____
2. _____ Year _____
3. _____ Year _____

Major Illnesses:

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 _____



Continued from page 7,

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. _____



Continued from page 8,

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 _____

BODY TEMPERATURE: I tend to be more _____. (warm/chilly)

HUNGER/THIRST:

My appetite (desire and ability to consume food) is (circle one) good fair poor

I tend to be _____ (very/ somewhat/never) **thirsty**.

If I am going to drink water, I prefer _____ (ice cold/cold/room temp/warm/hot) **water**.

Foods I crave: _____

Foods I can't stand: _____

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.



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
- Breast 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



*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.*