

## SMOKING CESSATION PROGRAM INTAKE

### PERSONAL CONTACT INFORMATION

*Our professional association requires us to maintain contact information for our patient records. No information will be provided to any other individual or group without your express permission. E-mail will only be used by our office to inform you of office events and will not be distributed for any other use.*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (cell): \_\_\_\_\_ (work): \_\_\_\_\_

Email address: \_\_\_\_\_ (fax): \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: Female \_\_\_ Male \_\_\_ Other \_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Have you ever had acupuncture before? **Y / N**

**ELIGIBILITY REQUIREMENTS:**

Do you have any of the following conditions (please check all that apply):

- Diabetes
- Cardiovascular disease
- Hypertension
- Schizophrenia
- Bleeding/clotting disorder (please specify): \_\_\_\_\_
- Active cancer (please specify): \_\_\_\_\_
- Currently pregnant
- Have a pacemaker
- Numbness or loss of sensation (please indicate locations):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all current medications:

Please list all current supplements:

Please list all allergies:

Is there anything you feel is important that is not covered here?

## **Informed Consent and Request for Naturopathic Medical Care with Dr. Pihowich**

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Kahlen Pihowich, ND, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, \_\_\_\_\_, hereby request and consent to examination and treatment with naturopathic medicine and acupuncture by Dr. Kahlen Pihowich, and/or other licensed doctors of naturopathic medicine or licensed acupuncturists serving as backup for her, hereafter called allied health care provider. I can request that students and preceptors not be included in my evaluation and treatment.

**I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Kahlen Pihowich, and/ or with the allied health care provider, providing backup:**

- 1.) My suspected diagnosis(es) or condition(s)
- 2.) The nature, purpose, goals and potential benefits of the proposed care
- 3.) The inherent risks, complications, potential hazards or side effects of treatment or procedure
- 4.) The probability or likelihood of success
- 5.) Reasonable available alternatives to the proposed treatment procedure
- 6.) Potential consequences if treatment or advice is not followed and/ or nothing is done

**I understand that a naturopathic evaluation and treatment may include, but are not limited to:**

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (including venipuncture, laboratory evaluation of blood, urine, stool and saliva)
- Soft tissue and osseous manipulation (including naturopathic/osseous manipulation of the spine and extremities)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Botanical/ herbal medicines (prescribing of various therapeutic substances including plant, mineral, and animal materials). Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water)
- Counseling (including but not limited to visualization for improved lifestyle strategies)

**The scope of practice of acupuncture is outlined below. I understand that traditional oriental medicine and acupuncture evaluation and treatment may include, but are not limited to:**

- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface)
- Moxa (indirect or direct burning of herbal material in the form of a loosely compacted herb or stick)
- Cupping (used to relieve symptoms of pain and chest congestion in which glass cups are placed on the skin with a vacuum created by heat)
- Dietary advice (based on traditional oriental medicine theory)
- Herbs (use of herbal formulas in the form of teas, powders, pastes, and plasters, which may be taken internally or used externally as a wash. Formulas may include shells, minerals, and animal materials)

**Please Initial:**

- I understand that Dr. Kahlen Pihowich, ND, is currently not licensed to prescribe drugs or any controlled substances.
  
- I understand that Dr. Kahlen Pihowich, ND, is not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.
  
- I recognize that even the gentlest therapies may potentially have complications in certain conditions, in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns including the possibility of pregnancy, and all medications, including over the counter drugs (eg. Tylenol) and supplements.

I do not expect Dr. Kahlen Pihowich and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Dr. Pihowich explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Printed Name of Guardian

\_\_\_\_\_  
Signature of Guardian

## Informed Consent and Request for Acupuncture with Dr. Marcoux

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Michelle Marcoux, ND, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, \_\_\_\_\_, hereby request and consent to treatment with acupuncture by Dr. Michelle Marcoux, ND.

### I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Michelle Marcoux:

- 1.) The nature, purpose, goals and potential benefits of the proposed care
- 2.) The inherent risks, complications, potential hazards or side effects of treatment or procedure
- 3.) The probability or likelihood of success
- 4.) Reasonable available alternatives to the proposed treatment procedure
- 5.) Potential consequences if treatment or advice is not followed and/ or nothing is done

### I understand that traditional oriental medicine and acupuncture evaluation and treatment may include, but are not limited to:

- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface)
- Tongue and pulse evaluation
- Auricular acupuncture (use of seeds and adhesive tape on the surface of the skin, at specific points in the ear)

**Potential risks:** Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching, loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat, hydrotherapies; allergic reaction to prescribed herbs, supplements; soft tissue or bony injury from physical manipulation; aggravation of pre-existing symptoms.

**Potential benefits:** Restoration of the body's maximal and optimal functioning capacity, relief or pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

**Notice to pregnant women:** All female patients must alert the provider if they have confirmed or suspect pregnancy as some therapies prescribed could present a risk to the pregnancy.

**Notice to individuals with bleeding disorders, pace makers, and/or cancer:** For your safety it is vital to alert your provider, Dr. Michelle Marcoux, ND, of these conditions.

**Please Initial:**

- I recognize that even the gentlest therapies may potentially have complications in certain conditions, in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns including the possibility of pregnancy, and all medications, including over the counter drugs (eg. Tylenol) and supplements.
  
- I do not expect Dr. Michelle Marcoux to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Dr. Marcoux explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.
  
- I further acknowledge that the cost and dates of the acupuncture sessions are fixed, and that no refunds or make up dates will be made for missed appointments.
  
- I also understand that Dr. Marcoux does **not** have a separate license for acupuncture, and as such, if insurance requires a separate license for acupuncture, then acupuncture sessions may be submitted as naturopathic services instead.

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Printed Name of Patient

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Signature of Patient

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Printed Name of Guardian (if under 16)

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Signature of Guardian

## **Welcome to your group acupuncture sessions!**

Please read the information below so you can be properly prepared for your first session.

- **CLOTHING:** please wear loose fitting clothes. Dr. Marcoux will need access to your feet, legs below your knees, hands, wrists, forearms, and top of your head. The fireplace will be on in order to provide warmth, however, if your feet tend to be cold, acupuncture can be done through thin socks or tights if preferred. Blankets are also provided if needed.
- **THINGS TO BRING:** you will be sitting with needles in for approximately 30 minutes. Relaxing music will be playing in the room but feel free to bring your own music, podcasts, meditations, etc. along with some headphones. Books or magazines may be brought as well, although needles in the wrists and arms may prevent movement of your hands to turn pages.
- **HYDRATION:** hydration before and after acupuncture is very important and will help to increase the benefits of the treatments. The needles will be stimulating blood and lymph flow, which increases the body's water requirements. Filtered water is available at the clinic, but feel free to bring your own bottle if desired.
- **INSURANCE COVERAGE:** if you have extended health benefits, these sessions may be covered either under naturopathic services OR acupuncture. Dr. Marcoux does NOT have a separate license number for acupuncture (it is all part of her naturopathic license), so please check with your insurance provider to determine which coverage is applicable.

Thank you and I look forward to our time together.