Naturopathic Family Physician 604.939.1059
Inlet Wellness Gallery info@inletwellnessgallery.com

Are you ready for a new way to look at your health and your life? Are you looking for a dynamic medicine that treats YOU rather than your symptoms? Welcome to the Inlet Wellness Gallery and our private medical practice that incorporates Naturopathic medicine, Acupuncture, Bowen therapy and more. We practice on the top floor of a heritage house that is full of art, and exudes a relaxing and healing atmosphere.

The philosophy of Naturopathic medicine is based on six vital concepts:

1.) The Healing Power of Nature
2.) First Do No Harm
3.) Identify and Treat the Cause
4.) Doctor as Teacher
5.) Prevention
6.) Treat the Whole Person

As Naturopathic doctors, we practice multiple disciplines. These include clinical nutrition, lifestyle counseling, botanical medicine, homeopathy, and physical medicine. We are also certified in Acupuncture and IV therapy, have special training in the use of Bio Identical Hormones, have our prescribing rights and practice Traditional Oriental Medicine as well as Bowen Therapy.

Working towards optimal health is a lifestyle. Not only do we aim to eliminate and prevent disease, we allow ourselves the experience to thrive in life on many levels. The process of achieving better health is not a 'quick fix'. It includes a deep look into one's lifestyle, goals, challenges; a journey that takes time and dedication. We are honored to work with you in pursuit of your optimal health and I look forward to helping you reach your full potential.

The initial visit is approximately 60 minutes. Follow-up visits will vary in length, depending on the complexity of the issues and the type of treatment applied.

Attached to this letter is your health questionnaire. We would like you to take time filling it out in your home, without any distractions. Please read the consent form and fee schedule thoroughly. If you have extended health care coverage for Naturopathic medicine, you will be responsible for reimbursement.

Thank you for your interest in health and we look forward to working with you.

Sincerely,

Dr. Krista Braun, ND & Dr. Briana Peddle, ND

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ADULT INTAKE

Name: _____ Date: _____

Address:_____

City: _____ Province: _____ Postal Code:_____

Phone # (home): _____ (cell)_____ (work): _____

Email address: _____

Date of Birth: _____ Age: _____ Gender: ____ Marital Status:_____

Occupation_____ Hours per week: _____

Do you have Extended Health Coverage? Y / N Are you on Premium Assistance through MSP? Y / N

How did you hear about this clinic? _____

Has any other family member already been a patient at this clinic? _____

Emergency contact: _____ Relationship: _____

Phone: _____ Address: _____

GENERAL

Height: _____ Weight: _____ Weight 1 year ago: _____Ideal Weight: _____

How often do you exercise per week? _____ Length of exercise?_____

Types of excerise_____

What is the average time you go to bed? _____ How many # of hours do you sleep per night? _____

Difficulty falling asleep? Y / N Difficulty staying asleep? Y / N Wake feeling rested? Y / N

Rate your: Stress level?_____ Energy level?_____ (1-10 with 10 being the highest)

Do you feel you are able to appropriately manage your stress levels? Y / N / Sometimes

Do you have a religious or spiritual practice? Y / N If so, what kind? _____

HEALTH CONCERNS

Please list your health concerns in *order* of *importance.*

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6)_____

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CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

What do you know about our approach as naturopathic doctors?

What three expectations do you have from this visit?
1.
2.
3.

What long-term expectations do you have from working with your naturopathic doctor?

What expectations do you have of me *personally* as your health care provider?

What is your present level of commitment to address and achieve your health goals?

(0%) 0 1 2 3 4 5 6 7 8 9 10 (100%)

What behaviors or lifestyle habits do you currently engage in regularly that you believe **support** your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are **self-destructive**?

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and adhering to the therapeutic protocols that I will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

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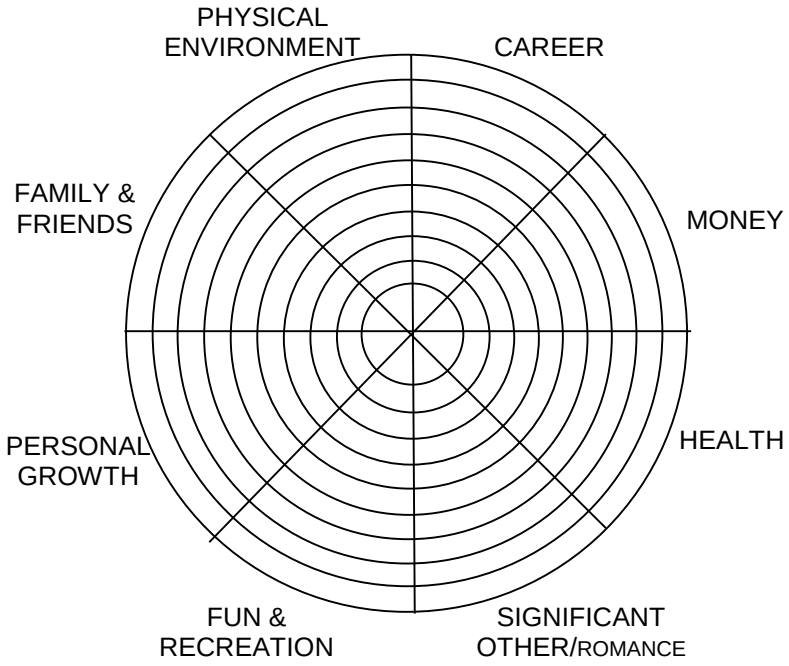
WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point radiating outward.



HEALTH CARE

Do you have a medical doctor? Y / N

Doctor's Name: _____(city:_____) Telephone:_____

Please list all current health care providers:

_____ Reason:_____

_____ Reason:_____

_____ Reason:_____

Do you have any known contagious diseases at this time? Y / N If yes, what?_____

When was the last time you received blood work?_____

How many times have you been treated with antibiotics?_____

FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (please circle and say who)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney disease	Epilepsy	Arthritis	High Cholesterol
Tuberculosis	Stroke	Anemia	Glaucoma
Asthma	Hay fever	Thyroid	Mental Illness

Any other relevant family history? _____What is your family heritage?_____

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CHILDHOOD ILLNESSES

Birth place: _____ Birth Weight: _____

Please circle whether you had any of the following as a child:

Rheumatic fever	Diphtheria	Scarlet fever	Chicken pox
German Measles	Measles	Mumps	

VACCINATIONS (please circle if yes)

Polio	Tetanus Shot	Flu Shot
MMR (Measles/Mumps/Rubella)	Diphtheria	
Pertussis	Hepatitis A / B	Other: _____

HOSPITALIZATIONS/ SURGERY/ IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs, ultrasounds have you had?

_____year _____ _____year _____

_____year _____ _____year _____

_____year _____ _____year _____

ALLERGIES

Do you have any ALLERGIES or sensitivities? (include medications, foods, environmental, chemicals, etc):

Allergen: _____ Reaction: _____
_____ Reaction: _____
_____ Reaction: _____

CURRENT MEDICATIONS

Are you currently taking any **NUTRITIONAL** supplements? Y / N

Name & Brand	Reason	Dosage	Date Started

Are you currently taking any **PRESCRIPTION** or Non-prescription drugs? Y / N

Name & Brand	Reason	Dosage	Date Started

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TYPICAL FOOD INTAKE (include drinks)

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Please indicate how often you consume the following: (Often, Sometimes, Rarely, Never)

Coffee	_____	Added Salt	_____	Pain Relievers	_____
Alcohol	_____	Soda Pop	_____	Laxatives	_____
Cigarettes	_____	Sugar	_____	Sleeping Pills	_____
Marijuana	_____	Tea (black)	_____	Antacids	_____
Steroids	_____	Sweeteners	_____	Other:	_____

REVIEW OF SYSTEMS

FOR THE FOLLOWING, PLEASE CIRCLE: **Y**= Yes **P**= in the Past **S** = Sometimes

NEUROLOGIC

Seizures	Y	P	S
Muscle weakness	Y	P	S
Loss of memory	Y	P	S
Vertigo or dizziness	Y	P	S
Paralysis	Y	P	S
Numbness or tingling	Y	P	S
Easily stressed	Y	P	S
Loss of balance	Y	P	S

HEAD & NECK

Chronic Headaches	Y	P	S
*Frequency:*_____			
*Location:*_____			
*Type: Migraine, Tension, other*_____			
History of Head injury	Y	P	S

SKIN

Rashes	Y	P	S
Acne/boils	Y	P	S
Change in skin color	Y	P	S
Lumps or bumps on skin	Y	P	S
Location:_____			
Eczema	Y	P	S
Excessive Itching	Y	P	S
Excessive hair loss	Y	P	S

ENDOCRINE

Hypothyroid	Y	P	S
Hyperthyroid	Y	P	S
Hypoglycemia	Y	P	S
Insomnia	Y	P	S
Fatigue	Y	P	S
Heat or cold intolerance	Y	P	S
Diabetes	Y	P	S
Excessive thirst	Y	P	S
Excessive hunger	Y	P	S
Seasonal depression	Y	P	S
Difficulty exercising	Y	P	S

IMMUNE

Reactions to immunizations	Y	P	S
Chronically swollen glands	Y	P	S
Slow wound healing	Y	P	S
Chronic fatigue syndrome	Y	P	S
Chronic infections	Y	P	S
Night sweats	Y	P	S

EARS

Impaired hearing	Y	P	S
Ringing in ears	Y	P	S
Dizziness	Y	P	S
Earaches	Y	P	S

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EYES

Impaired vision	Y	P	S
Cataracts	Y	P	S
Glaucoma	Y	P	S
Spots in vision	Y	P	S
Color blindness	Y	P	S
Tearing or dryness	Y	P	S
Eye pain or strain	Y	P	S

NOSE AND SINUS

Frequent colds	Y	P	S
Nasal Congestion	Y	P	S
Sinus problems	Y	P	S
Nose bleeds	Y	P	S
Hay fever	Y	P	S
Loss of smell	Y	P	S

MOUTH AND THROAT

Goiter	Y	P	S
Difficulty swallowing	Y	P	S
Pain or stiffness in neck	Y	P	S
Frequent sore throat	Y	P	S
Copious saliva			
Dry mouth	Y	P	S
Sore tongue or lips	Y	P	S
Hoarseness	Y	P	S
Jaw or TMJ problems	Y	P	S
Teeth grinding	Y	P	S
Gum problems	Y	P	S
Dental cavities	Y	P	S

*How many:*_____
*Filling type:*_____

BLOOD

Anemia	Y	P	S
Easy bleeding or bruising	Y	P	S
Cold hands/feet	Y	P	S
Deep leg pain	Y	P	S
Thrombophlebitis	Y	P	S
Varicose veins	Y	P	S

RESPIRATORY

Cough	Y	P	S
Asthma	Y	P	S
Wheezing	Y	P	S
Bronchitis	Y	P	S
Coughing up blood	Y	P	S
Shortness of breath	Y	P	S
Painful breathing	Y	P	S
Emphysema	Y	P	S
Tuberculosis	Y	P	S

GASTROINTESTINAL

Change in thirst	Y	P	S
Change in appetite	Y	P	S
Nausea/vomiting	Y	P	S
Ulcer	Y	P	S
Jaundice	Y	P	S
Gall bladder disease	Y	P	S
Liver disease	Y	P	S
Hemorrhoids	Y	P	S
Pancreatitis	Y	P	S
Heartburn	Y	P	S
Abdominal pain or cramps	Y	P	S
Belching or passing gas	Y	P	S
Constipation			
Diarrhea	Y	P	S
Bowel movements: how often?_____			
Is this a change?_____			
Black stools	Y	P	S
Blood in stools	Y	P	S

MENTAL/EMOTIONAL

Treated for emotional problem	Y	P	S
Depression	Y	P	S
Anxiety or nervousness	Y	P	S
Poor concentration	Y	P	S
Do you have mood swings	Y	P	S
Considered suicide	Y	P	S
Attempted suicide	Y	P	S
Tension	Y	P	S
Memory problems	Y	P	S
Have a history of abuse	Y	P	S
Experienced a major trauma	Y	P	S
Treated for drug dependence	Y	P	S

URINARY

Increase urination frequency	Y	P	S
Inability to hold urine	Y	P	S
Pain in urination	Y	P	S
Frequency at night	Y	P	S
Frequent UTI's	Y	P	S
Kidney stones	Y	P	S

MUSCULOSKELETAL

Joint pain or stiffness	Y	P	S
Arthritis	Y	P	S
Broken bones	Y	P	S
Weakness	Y	P	S
Muscle spasms or cramps	Y	P	S
Sciatica	Y	P	S

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FEMALE REPRODUCTIVE

Age of first menses:_____
Age of last menses (if menopausal):_____
Length of cycle:_____days
Duration of menses:_____ days

Are your cycles regular?	Y	P	S
Painful menses	Y	P	S
Heavy or excessive flow	Y	P	S
PMS	Y	P	S

Symptoms:_____
_____

Bleeding between cycles	Y	P	S
Clotting	Y	P	S
Endometriosis	Y	P	S
Ovarian cysts	Y	P	S
Vaginal odor	Y	P	S
Vaginal discharge	Y	P	S

Date of last pap smear:_____

Abnormal PAP	Y	P	S
Cervical dysplasia	Y	P	S
Are you sexually active	Y	P	S

Birth control? Type:_____

Pain during intercourse	Y	P	S
Gonorrhea	Y	P	S
Herpes	Y	P	S
Chlamydia	Y	P	S
Genital warts	Y	P	S
Syphilis	Y	P	S
Difficulty conceiving	Y	P	S

Number of pregnancies:_____
Number of live births:_____
Number of miscarriages:_____
Number of abortions:_____

Do you do self breast exams	Y	P	S
Breast pain/tenderness	Y	P	S
Breast lumps	Y	P	S
Nipple discharge	Y	P	S
Menopausal symptoms	Y	P	S

MALE REPRODUCTIVE

Are you sexually active	Y	P	S

Birth control? Type:_____

Discharge or sores	Y	P	S
Chlamydia	Y	P	S
Gonorrhea	Y	P	S
Genital warts	Y	P	S
Herpes	Y	P	S
Syphilis	Y	P	S
Hernias	Y	P	S
Testicular masses	Y	P	S
Testicular pain	Y	P	S
Prostate disease	Y	P	S
Impotence	Y	P	S
Premature ejaculation	Y	P	S

Thank you & Welcome! We are looking forward to working with you on your path to better health!

Informed Consent and Request for Naturopathic Medical Care and Acupuncture

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 the naturopathic doctor, 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 the primary naturopathic doctor (please √):

☐ **Dr. Krista L. Braun, ND**

☐ **Dr. Briana Peddle, ND**

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 the naturopathic doctor, 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, pap smears, diagnostic imaging, 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): oral, IV or intramuscular use
- Hydrotherapy (use of hot and cold water)
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Bowen therapy (gentle physical therapy)
- Pharmacy prescription
- IV therapy: vitamins and immune boosting remedies bypass the sometimes inefficient absorption of the digestive system. This is especially useful in treating conditions such as colds and the flu, chronic fatigue, chronic digestive problems and stress. Potential risks: there is a low risk of allergic reaction, bruising, swelling, and or pain.

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)

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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 of these conditions.

Please Initial:

☐ I understand that Dr. Krista L. Braun, ND and Dr. Briana Peddle, ND, are currently licensed to prescribe prescription medications, excluding Schedule F Drugs (narcotics).

☐ I understand that Dr. Krista L. Braun, ND and Dr. Briana Peddle, ND, are not psychologists or psychiatrists. 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. Krista L. Braun and/or Dr. Briana Peddle 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 my ND 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

Fee Schedule 2016

(Please Note: The fee schedule may change at <u>anytime</u> and is in line with the fee recommendations stated by the British Columbia Naturopathic Association).

First office visit (60 minutes)	$170
Pediatric first office visit (0-12yrs) (45 minutes)	$105
Return visit (adult)	
30 minutes	$90
45 minutes	$105
60 minutes	$120
Women's Wellness Exam (including PAP smear) (60min)	$120
Acupuncture Session	$100
Special Pricing for Acupuncture	
Biweekly	$55
Weekly	$80
Return visit (child) (30 minutes)	$90
Bowen Therapy Session	$100
IV Push (30min)	$90
Brief Visit (15min)	$45

Phone AND email consultations fees same as return visit fees.

Lab work and supplements prescribed by your naturopathic doctor are an additional cost and not included in the visit fee.

Please note: The patient is responsible for payment at the time of service, unless previously arranged by your naturopathic doctor. A portion of your visit may be claimed through your extended health coverage, or if you have premium assistance through MSP. You will be billed for phone consultations and e-mail correspondence, except those regarding questions about prescribed treatments and conditions already being treated. ***Because fees are subject to change, please confirm at time of booking.***

Cancellation policy: Any appointments cancelled with less than 24 hours notice will be subject to a cancellation fee, as per policy instated by the Inlet Wellness Gallery.

* I have reviewed the above fees and understand that I am responsible for payment at the time of service, unless previously arranged by Dr. Braun or Dr. Peddle. I also understand that I will be billed for phone consultations and e-mail correspondence. **I also understand that I will be charged for appointments cancelled without 24 hours notice, except in cases of emergency.**

Signed: _____ Date: _____

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