

**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. Sarah Nyrose, ND (locum for Dr. Krista Braun, ND until Fall 2017)**

**&**

**Dr. Briana Peddle, ND**

PEDIATRIC INTAKE FORM (BIRTH TO 5 YEARS)

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: Female / Male

Parent/Guardian's Name: \_\_\_\_\_ Insurance Plan: \_\_\_\_\_

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

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

Telephone (home): \_\_\_\_\_ (Parent's work): \_\_\_\_\_

Parent's email address: \_\_\_\_\_

How did you hear about this clinic? \_\_\_\_\_

If internet: Google: \_\_\_\_\_ BCNA Website: \_\_\_\_\_ CNPBC Website: \_\_\_\_\_ Other: \_\_\_\_\_

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

Name of doctor's office/hospital/clinic where your child's health records are kept: \_\_\_\_\_

Reason for referral or presenting problems: \_\_\_\_\_

HEALTH HISTORY QUESTIONNAIRE

Birth city & state: \_\_\_\_\_ Birth time: \_\_\_\_\_ Birth weight: \_\_\_\_\_

What are your child's most important health problems? List as many as you can in order of importance:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

Does your child have a contagious disease at this time? Y / N

If yes, what? \_\_\_\_\_

MEDICATIONS / SUPPLEMENTS

NOW	PAST		NOW	PAST
_____	_____	Aspirin	_____	_____
_____	_____	Tylenol	_____	_____
_____	_____	Antibiotics	_____	_____
_____	_____	Ibuprofen	_____	_____
			_____	_____
			Decongestants	
			Anti-histamine	
			Other	

Allergies to medicines: \_\_\_\_\_

Nutritional supplements your child is taking: \_\_\_\_\_

**MEDICAL HISTORY**

- |                                      |  |   |
|--------------------------------------|--|---|
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Scarlet fever   | <input type="checkbox"/> Tonsillitis, approx no. of times: _____    |
| <input type="checkbox"/> Measles     | <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Ear infections, approx no. of times: _____ |
| <input type="checkbox"/> Mumps       | <input type="checkbox"/> Frequent colds  | <input type="checkbox"/> Strep throat, approx no. of times: _____   |
| <input type="checkbox"/> Rubella     | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Other: _____                               |

Has your child ever had any of the following? WHEN WHERE RESULTS

Electroencephalogram (EEG): \_\_\_\_\_

Psychological evaluations: \_\_\_\_\_

Hearing test: \_\_\_\_\_

Speech/language tests: \_\_\_\_\_

Injuries/surgeries/hospitalizations (please list): \_\_\_\_\_

**IMMUNIZATIONS**

- |                                  |                                     |                                       |                          |
|----------------------------------|-------------------------------------|---------------------------------------|--------------------------|
| <input type="checkbox"/> MMR     | <input type="checkbox"/> DPT        | <input type="checkbox"/> Chicken pox  | Others: _____            |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Small pox    | Adverse reactions: Y / N |
| <input type="checkbox"/> Mumps   | <input type="checkbox"/> Tetanus    | <input type="checkbox"/> H. influenza | If so, what? _____       |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Polio      | <input type="checkbox"/> The flu      | _____                    |

**FAMILY HISTORY**

- |   |                                       |   |
|---|---------------------------------------|---|
| <input type="checkbox"/> Heart disease  | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Birth defects            |
| <input type="checkbox"/> Hypertension   | <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Cancer         | <input type="checkbox"/> Allergies    | <input type="checkbox"/> Asthma                   |
| <input type="checkbox"/> Mental illness | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other significant: _____ |

**PRENATAL HISTORY**

Previous pregnancies by natural mother, miscarriages, or complications? \_\_\_\_\_

Mother's age at child's birth: \_\_\_\_\_

Did mother receive prenatal care? Y / N

Prenatal Vitamins? Y / N

Mother's health during pregnancy:

- |                                      |                                       |  |
|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Bleeding    | <input type="checkbox"/> Nausea       | <input type="checkbox"/> Physical or emotional trauma          |
| <input type="checkbox"/> Illnesses   | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Cigarettes, alcohol, drug consumption |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Thyroid problems                      |

**BIRTH HISTORY**

Term: \_\_\_\_\_ Full \_\_\_\_\_ Premature \_\_\_\_\_ Late \_\_\_\_\_ Length of labor

Type of birth (home, hospital, C-section) \_\_\_\_\_

Complications: \_\_\_\_\_ Birth city & province: \_\_\_\_\_

# Naturopathic Family Physician

Inlet Wellness Gallery

604.939.1059

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Birth time: \_\_\_\_\_ Birth weight: \_\_\_\_\_

Did your child have any of the following problems shortly after birth?

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Rashes       | <input type="checkbox"/> Birth injuries | <input type="checkbox"/> Blue baby      |
| <input type="checkbox"/> Jaundice     | <input type="checkbox"/> Seizures       | <input type="checkbox"/> Cerebral palsy |
| <input type="checkbox"/> Colic        | <input type="checkbox"/> Fever          | <input type="checkbox"/> Birth defects  |
| <input type="checkbox"/> Other: _____ |   |   |

Child's sleep patterns (1st year): \_\_\_\_\_

Food intolerances: \_\_\_\_\_

Breast fed: Y / N    How long: \_\_\_\_\_    Formula: Y / N    Type (milk, soy): \_\_\_\_\_

Age began solids: \_\_\_\_\_    Which foods: \_\_\_\_\_

Age began:    Sitting \_\_\_\_\_    Crawling \_\_\_\_\_    Walking \_\_\_\_\_    Talking \_\_\_\_\_

## ALLERGIES

Is your child hypersensitive or allergic to:

Any drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Any environmental? \_\_\_\_\_

Breast fed? \_\_\_\_\_ how long? \_\_\_\_\_ Formula? \_\_\_\_\_ milk / soy \_\_\_\_\_

## SYMPTOMS

- |                                       |   |   |  |
|---------------------------------------|---|---|--|
| <input type="checkbox"/> Hives        | <input type="checkbox"/> Burning urine      | <input type="checkbox"/> Bloody uring       | <input type="checkbox"/> Eczema        |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Bleeding gums      | <input type="checkbox"/> Heart murmur       | <input type="checkbox"/> Nervous       |
| <input type="checkbox"/> Nose bleeds  | <input type="checkbox"/> Vomiting spells    | <input type="checkbox"/> Sleep problems     | <input type="checkbox"/> Asthma        |
| <input type="checkbox"/> Acne         | <input type="checkbox"/> Anemia             | <input type="checkbox"/> Night sweats       | <input type="checkbox"/> High fevers   |
| <input type="checkbox"/> Jaundice     | <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Chronic rash       | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Hearing loss       | <input type="checkbox"/> Easy bruising      | <input type="checkbox"/> Sore throats  |
| <input type="checkbox"/> Flat feet    | <input type="checkbox"/> No appetite        | <input type="checkbox"/> Body/breath odor   | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Nightmares   | <input type="checkbox"/> Frequent colds     | <input type="checkbox"/> Bleeding tendency  | <input type="checkbox"/> Unusual fears |
| <input type="checkbox"/> Wheezing     | <input type="checkbox"/> Joint pains        | <input type="checkbox"/> Excessive fatigue  | <input type="checkbox"/> Cough         |
| <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Hair loss          | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Allergies     |

## DIET

Please describe your child's typical daily diet:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

To drink: \_\_\_\_\_

*Thank you & Welcome! It is an honor to work with you and your child!*

## **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. Sarah Nyrose, ND (locum for Dr. Krista L. Braun, ND until Fall 2017)**

**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, topical 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 of 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 (Dr. Sarah Nyrose, 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 (Dr. Sarah Nyrose, 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 (Dr. Sarah Nyrose, ND) 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

**(Please Note: The fee schedule may change at any time and is in line with the fee recommendations stated by the British Columbia Naturopathic Association).**

<b>First office visit</b> (60 minutes)	\$170
<b>Pediatric first office visit (0-12yrs)</b> (45 minutes)	\$105
<b>Return visit (adult)</b>	
30 minutes	\$90
45 minutes	\$105
60 minutes	\$120
<b>Women's Wellness Exam (including PAP smear) (60min)</b>	\$120
<b>Acupuncture Session</b>	\$100
<b>Special Pricing for Acupuncture</b>	
2 <sup>nd</sup> Acup visit in the same week	\$55
Weekly	\$80
<b>Return visit (child)</b> (30 minutes)	\$90
<b>Bowen Therapy Session</b>	\$100
<b>IV Push (30min)</b>	\$90
<b>Brief Visit (15min)</b>	\$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 (Dr. Nyrose) 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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