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. Sarah Nyrose, ND (locum for Dr. Krista Braun, ND until Fall 2017)
&
Dr. Briana Peddle, ND

604.939.1059
info@inletwellnessgallery.com

PEDIATRIC INTAKE FORM (6-12 years)

Name:____Date: ________________________

Age: ________ Date of Birth: ________/________/________ Female: ____________ Male: _____________

Mother's name:______________________________ Father's name:_________________________________

Address: ____

City:_______________________________________ Province:_____________ Postal Code:___________

Phone # (home): (______)________________________ Parent's # (work): (______)______________________

Parent's e-mail address: ____

How did you hear about our clinic?____

HEALTH HISTORY QUESTIONNAIRE

Birth place: ____________________________ 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? ____

Previous Illnesses

Rheumatic fever	Y / N	German measles	Y / N
Chicken pox	Y / N	Measles	Y / N
Tonsillitis	Y / N	approx. # of times:	____
Ear infections	Y / N	approx. # of times:	____
Other	Y / N	list: __________________________________	

Has your child had any of the following tests? When_______________ Where________________________

Electroencephalogram (EEG)____

Psychological evaluation____

Hearing tests____

Speech/Language tests____

604.939.1059
info@inletwellnessgallery.com

Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?
____
____

Immunizations

	U – Up to Date ***P – Partial***	***N – Not done***
Pre-School	________ HBV (Hepatitis B)	________ HAV (Hepatitis A)
	________ Hib (Hemophilus influenza type B)	________ IPV (Polio)
	________ Varicella (chicken pox)	________ DTaP (Diphtheria, Tetanus, Pertussis)
	________ MMR (Measles, Mumps, Rubella)	________ PCV (Pneumococcal Bacteria)
School Age	________ Td (Tetanus, Diphtheria)	________ MCV4 (Meningitis)
Other	________ Influenza	________ Other (Please list):________________

Reactions to Immunizations? ____

Allergies

Is your child hypersensitive or allergic to:

Any drugs?____

Any foods? ____

Any environmentals?____

Breast fed? _____________ how long? ______________ Formula? ______________ milk / soy _______________

Typical Food Intake

Breakfast:____

Lunch: ____

Dinner: ____

Snacks: ____

To Drink: ____

Medications/Supplementation

Please list any prescription medications, over the counter medications, vitamins or other supplements your child is taking:

1) ____________________________________ 5) ______________________________

2) ____________________________________ 6) ______________________________

3) ____________________________________ 7) ______________________________

604.939.1059
info@inletwellnessgallery.com

4) ____ 8) ____

Habits

Main interests and hobbies: ____

Day Care ☐ School ☐ Home school ☐ Grade Level:__________________________________

Does your child watch TV? Y / N How many hours per day? ____________________________

Does your child read? Y / N How many hours per day? ____________________________

Does your child play video games? Y / N How many hours per day? ____________________________

Does your child play sports? Y / N How many hours per day? ____________________________

Are there any pets in the home? Y / N What kind? ____

Anyone in the home smoke? Y / N

Social History

Whom does the child live with? ______________________ Are the parents divorced / separated? Y / N

If so, what are the arrangements made with the other parent (eg. visitation etc.)?_______________________

List the age and gender of siblings. Indicate half, step or deceased as applicable.

1. ____________________________________ 2. ______________________________________

3. ____________________________________ 4. ______________________________________

5. ____________________________________ 6. ______________________________________

CONTEXT OF CARE REVIEW

What three expectations do you have from this visit to our clinic?

What long term expectations do you have from working with our clinic?

Is there any information about your child's health that you would like to add?

What expectations do you have for your child from working with our clinic?

604.939.1059
info@inletwellnessgallery.com

REVIEW OF SYSTEMS

Y= Yes **N**= No, never **P**=signification problem in the past **S**= Sometimes a problem

MENTAL/ EMOTIONAL

Mood Swings	Y	P	N	S
Irritability	Y	P	N	S
Hyperactivity	Y	P	N	S
Introvert/extrovert	Y	P	N	S
Motion/car sickness	Y	P	N	S
Anxiety/nervousness	Y	P	N	S
Cries easily	Y	P	N	S
Unusual fears	Y	P	N	S
Sleep problems	Y	P	N	S
Nightmares	Y	P	N	S

ENDOCRINE

Heat/cold intolerance	Y	P	N	S
Fatigue	Y	P	N	S
Excessive thirst	Y	P	N	S
Excessive hunger	Y	P	N	S
Low blood sugar	Y	P	N	S
High blood sugar	Y	P	N	S

SKIN

Rashes	Y	P	N	S
Eczema, Hives	Y	P	N	S
Acne, Boils	Y	P	N	S
Itching	Y	P	N	S

HEAD

Headaches	Y	P	N	S
Head Injury	Y	P	N	S
Dizzy spells	Y	P	N	S
High fevers	Y	P	N	S

EYES

Glasses or contacts	Y	P	N	S
Tearing or dryness	Y	P	N	S
Eye pain/strain	Y	P	N	S

EARS

Earaches	Y	P	N	S
Impaired hearing	Y	P	N	S

NOSE AND SINUSES

Frequent colds	Y	P	N	S
Nose Bleeds	Y	P	N	S
Stuffiness	Y	P	N	S
Hayfever	Y	P	N	S
Sinus problems	Y	P	N	S
Loss of smell	Y	P	N	S

MOUTH AND THROAT

Frequent sore throat	Y	P	N	S
Canker sores	Y	P	N	S
Breath odor	Y	P	N	S

RESPIRATORY

Cough	Y	P	N	S
Wheezing	Y	P	N	S
Asthma	Y	P	N	S
Bronchitis	Y	P	N	S

CARDIOVASCULAR

Heart disease	Y	P	N	S
Murmurs	Y	P	N	S

URINARY

Frequent urination	Y	P	N	S
Bed wetting	Y	P	N	S

GASTROINTESTINAL

Belching/passing gas	Y	P	N	S
Stomach aches	Y	P	N	S
Constipation	Y	P	N	S
Diarrhea	Y	P	N	S

Bowel Movements How often?________

MUSCULOSKELETAL

Joint pain/stiffness	Y	P	N	S
Muscle spasms/cramps	Y	P	N	S
Broken bones	Y	P	N	S

BLOOD/PERIPHERAL VASCULAR

Anemia	Y	P	N	S
Easy bleeding/bruising	Y	P	N	S

Thank you! We are looking forward to working with you and your child!

604.939.1059
info@inletwellnessgallery.com

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, 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)

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 (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 anytime 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	
2nd Acup visit of the week	$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 (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: ______________

604.939.1059
info@inletwellnessgallery.com