Dr. Krista Braun, BSc., ND
Naturopathic Family Physician

Inlet Wellness Gallery
2320 Clarke St Port Moody

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 my private medical practice that incorporates Naturopathic medicine, Acupuncture, and Bowen therapy. I practice on the top floor of a heritage house that is full 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 a Naturopathic doctor, I practice multiple disciplines. These include nutrition, lifestyle counseling, botanical medicine, homeopathy, physical medicine and stress management. I am certified in Acupuncture 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. I am 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. I would like you to take time filling it out in your home, with out distraction. 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.

I thank you for your interest in health and look forward to working with you.

Sincerely,

Dr. Krista

Dr. Krista L. Braun, BSc, ND
Naturopathic Family Physician

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	____	____ Decongestants
____	____ Tylenol	____	____ Anti-histamine
____	____ Antibiotics	____	____ Other______________________________________
____	____ Ibuprofen		

Allergies to medicines: ____

Nutritional supplements your child is taking: ____

____

MEDICAL HISTORY

____ Chicken pox ____ Scarlet fever ____ Tonsillitis, approx no. of times: ______________
____ Measles ____ Pneumonia ____ Ear infections, approx no. of times: ___________
____ Mumps ____ Frequent colds ____ Strep throat, approx no. of times: ____________
____ Rubella ____ Rheumatic fever ____ 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

____ MMR ____ DPT ____ Chicken pox Others:________________________
____ Measles ____ Diphtheria ____ Small pox Adverse reactions: Y / N
____ Mumps ____ Tetanus ____ H. influenza If so, what? ______________________
____ Rubella ____ Polio ____ The flu ________________________________

FAMILY HISTORY

____ Heart disease ____ Diabetes ____ Birth defects
____ Hypertension ____ Arthritis ____ Tuberculosis
____ Cancer ____ Allergies ____ Asthma
____ Mental illness ____ Osteoporosis ____ 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:

____ Bleeding ____ Nausea ____ Physical or emotional trauma
____ Illnesses ____ Hypertension ____ Cigarettes, alcohol, drug consumption
____ Medications ____ Diabetes ____ Thyroid problems

BIRTH HISTORY

Term: _____ Full _____ Premature ______ Late _______ Length of labor

Type of birth (home, hospital, C-section) ____

Complications:_______________________________ Birth city & province: _______________________

Birth time: ____________ Birth weight:______________

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

____ Rashes ____ Birth injuries ____ Blue baby

____ Jaundice ____ Seizures ____ Cerebral palsy

____ Colic ____ Fever ____ Birth defects

____ 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 environmentals?____

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

SYMPTOMS

____ Hives
____ Cries easily
____ Nose bleeds
____ Acne
____ Jaundice
____ Diarrhea
____ Flat feet
____ Nightmares
____ Wheezing
____ Dizzy spells
____ Burning urine
____ Bleeding gums
____ Vomiting spells
____ Anemia
____ Sensitive to light
____ Hearing loss
____ No appetite
____ Frequent colds
____ Joint pains
____ Hair loss
____ Bloody uring
____ Heart murmur
____ Sleep problems
____ Night sweats
____ Chronic rash
____ Easy bruising
____ Body/breath odor
____ Bleeding tendency
____ Excessive fatigue
____ Frequent urination
____ Eczema
____ Nervous
____ Asthma
____ High fevers
____ Stomach aches
____ Sore throats
____ Constipation
____ Unusual fears
____ Cough
____ 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 Dr. Krista L. Braun, 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. Krista L. Braun, 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. Krista L. Braun, 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)
- Hydrotherapy (use of hot and cold water)
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Bowen therapy (gentle physical therapy)

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, Dr. Krista L. Braun, ND, of these conditions.

Please Initial:

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

☐ I understand that Dr. Krista L. Braun, 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. Krista L. Braun 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. Braun 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

The following fee schedule does not include HST.

First office visit (60 minutes)	$145.00
Pediatric first office visit (0-12yrs) (30 minutes) Note: If either parent is a patient of Dr. Braun's, initial visit for the child is of no cost.	$70.00
New patient acute visit (15-20 mintues)	$70.00
Return visit (adult) (30 minutes)	$70.00
Return visit (child) (30 minutes)	$60.00
Bowen Therapy (30-45 minutes)	$80.00
Acupuncture	$90.00 (45 minute session) $110.00 (60 minute session)

Phone consultations AND email fees same as return visit fees.

Lab work and supplements prescribed by Dr. Braun are an additional cost and not included in the visit fee.

Please note: Patient is responsible for payment at the time of service, unless previously arranged by Dr. Braun. A portion of your visit may be claimed through your extended health coverage, or if you have premium assistance through MSP. We are happy to provide Seniors (65 yrs of age and over) a 10% discount off of all visits and most medicines. There is no additional charge for physical exams or PAP exams. All other testing is done at additional charge. 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 $60.00 cancellation fee.

I clearly understand that Dr. Braun is not a medical doctor, but a naturopathic doctor who practices with natural therapeutics.

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. I also understand that I will be billed for phone consultations and e-mail correspondence, except those regarding questions about prescribed treatments and conditions already being treated.

I also understand that I will be charged $60.00 for appointments cancelled without 24 hours notice, except in cases of emergency.

Signed: ____ Date: __________________________

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