

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 (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 _____

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 environmental? _____

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) _____ |
| 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?

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!

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)	\$70.00
Note: If either parent is a patient of Dr. Braun's, initial visit for the child is of no cost.	
New patient acute visit (15-20 minutes)	\$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: _____