Greenwood
Wellness Clinic™
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Dear New Patient,

Welcome to Greenwood Wellness Clinic. We believe in a holistic approach to health with a focus on prevention and treatment of disease using natural methods. We look forward to working with you to achieve all of your health goals. In booking an appointment with us you are taking an active role in your health care - a key component to achieving optimum health and well-being.

Before your visit, please take the time to fill out the intake form and diet diary. Your responses provide valuable information that is incorporated into a comprehensive assessment and finally a personalized treatment plan. Typically an initial visit will be 1½ - 2 hours in length. It consists of a detailed review of the intake form and any other important information that arises. Most new patients undergo a Biological Terrain Assessment and darkfield microscopy exam – please talk to our staff or check our website to determine if these tests are appropriate for you and for instructions. In addition, a complaint-oriented physical exam will be performed and specific lab testing completed based on each individual case. It is also important that if you have had any laboratory testing done within the past 6 months to bring a copy of these results with you on your first visit. If you have any difficulty gaining access to theses documents, you can contact our office and we will provide a “Release of Records” form to assist you.

Based on all of this information a personalized treatment plan will be developed. Treatments may include dietary and lifestyle changes, nutritional supplementation, botanical medicines, homeopathic remedies and/or acupuncture. Your progress will be assessed on follow-up visits and tests repeated as needed. The length of treatment and frequency of follow-up visits varies with each individual. If you have any questions during any part of your visit, please do not hesitate to ask. It is our goal to provide you with as much information as possible and to make your visits as satisfying as possible.

Please ask our staff or see our website for directions to the clinic. On arrival, please come to the lower level entrance. If you have not yet filled out the intake form please plan to arrive 15 minutes early. Please contact our office for details on our fee schedule. Payment is appreciated upon rendering of services. The clinic accepts Visa, MasterCard, cheque and/or cash for services. Please note that our office is scent free to respect those clients with allergies or sensitivities.

We look forward to working with you and improving your health holistically.

Lindsay Bast, B.Sc., Naturopathic Doctor
John Pronk, B.Sc., Naturopathic Doctor

Child Intake Form

(to be completed by parent/guardian)

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____ Postal Code: _____

Parent/guardian names: _____

Telephone (home): _____ Work: _____ Fax: _____

May we leave messages related to your child's visits? Y / N

Referred by: _____

Emergency Contact name: _____

Telephone: _____ Relation: _____

1. Please state your child's primary reason for attending our clinic. Please list the first time you noticed the condition and describe any factors that you feel are associated to the onset and development:

2. Please list any other current health concerns:

3. Please list past health problems and dates including any hospitalizations or surgery:

4. Please list any allergies (environmental, food, medication etc.)

5. Please list any current medications or supplements your child is taking

6. Please list any past medications or supplements your child has taken

7. Has your child been immunized? (please check immunizations received)
   _____ Polio
   _____ Diptheria
   _____ Pertussis
   _____ Tetanus
   _____ Measles
   _____ Mumps
   _____ Rubella
   _____ Influenza (flu shot)
   _____ Hepatitis B
   _____ Haemophilus influenza B
   _____ Chicken Pox
   _____ Other: _____

8. Did your child have any adverse reaction to a vaccination? No _____ Yes _____ Please explain.

9. Please circle any medical conditions possessed by your child's mother, father, brothers or sisters:

Condition	Family Member	Condition	Family Member
Cancer		Asthma	
Congenital/genetic abnormality		Epilepsy	
Diabetes		Allergies	
Heart Disease		Mental Illness	
Multiple Sclerosis		Alcoholism	
Obesity		Thyroid problems	
Osteoarthritis		Psoriasis	
Rheumatoid Arthritis		Eczema	

10. What was the general health of the parents at the time of conception?

11. How was the health of the mother during the pregnancy?

12. Was your child breast-fed? No_____ Yes_____ for how long? _____

13. General symptoms (make a ✓ for current; ✕ for past symptoms)

__ Hives	__ Cough	__ Cries easily
__ Eczema	__ Burning urination	__ Unusual fears
__ Acne	__ Stomach aches	__ Night sweats
__ Chronic rash	__ Constipation	__ Sensitive to light
__ Excessive fatigue	__ Diarrhea	__ Body/breath odour
__ Sore throats	__ Gas	__ Motion/car sickness
__ Frequent colds	__ No appetite	__ Frequent headaches
__ Canker sores	__ Vomiting spells	__ Joint pains
__ High fevers	__ Bleeding gums	__ Hearing loss
__ Easy bruising	__ Jaundice	__ Heart murmur
__ Dizzy spells	__ Nose bleeds	__ Flat feet
__ Anemia	__ Wheezing	__ Ear infections
__ Pneumonia	__ Asthma	__ Allergies
__ Scarlet fever	__ Seizures	__ Bed wetting

14. Is there anything else you feel has not been covered?

Patient Diet Diary

Before your visit please complete the following diet diary for three days (if possible include one day on the weekend). Record anything you eat or drink and the amount as precisely as possible (e.g. ¾ cup raisin bran; ½ cup 1% milk etc.).

Day 1		Day 2		Day 3	
Amount	Food	Amount	Food	Amount	Food