



Diana R. Crumrine ND
1416 W Washington St
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www.myfoothillsfamilymed.com

Acute Intake Form

Name: _____ Date of Birth: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): () _____ (work): () _____ (cell): () _____

Email address: _____

Education: _____ Occupation: _____ Hours/wk: _____

Employer: _____ Work address: _____

Status (circle): Single Married Separated Divorced Widowed Partnership

Live with (circle): Spouse Partner Parents Children Friends Alone

Name of spouse/partner: _____

Name of parent(s) or guardian(s): _____ Relationship to you: _____

Emergency Contact: _____ Relationship to you: _____

Phone (home): () _____ (work): () _____ (cell): () _____

Address: _____

How did you hear about this clinic? _____

Any family members currently a patient at this clinic? _____

Have you ever seen a Naturopathic Doctor (ND) before? Yes / No

Would you like to receive health newsletters and education articles from the clinic as they become available? Yes / No

CURRENT PROBLEM LIST

What are your most important health problems? List as many as you can in order of importance and include time of onset

1. _____

5. _____

2. _____

6. _____

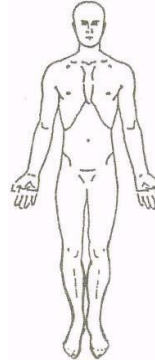
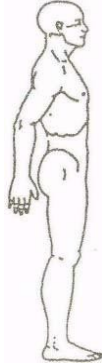
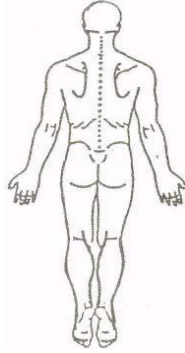
3. _____

7. _____

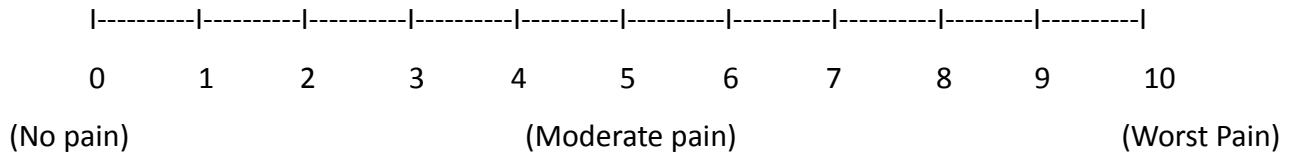
4. _____

8. _____

Please mark your areas of pain



Please indicate your CURRENT pain level on the chart below:



Please list any current diagnoses:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Do you have any known contagious diseases at this time? Y / N If yes, what? _____

GENERAL

Height: _____ Weight: _____ Gender: Male / Female

Are you currently receiving health care? Y / N

If yes where and from who? _____

If no, are you planning to establish primary care with us? Y / N

When and where did you last receive medical or health care? _____

What was the reason? _____

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental or chemical? _____



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MEDICATION

Please list **all medications** (including over the counter) that you are currently taking and why. Please indicate dose and frequency.

_____ Start date _____ Start date _____
_____ Start date _____ Start date _____
_____ Start date _____ Start date _____
_____ Start date _____ Start date _____

Have you taken Aspirin, Ibuprofen, Naproxen or any steroids for a long period of time (3 weeks or longer)? Y / N

If yes for how long and for what? _____

VITAMINS AND SUPPLEMENTS

Please list all vitamins and supplements you are taking and why (Please indicate dose and frequency)

_____ Start date _____ Start date _____
_____ Start date _____ Start date _____
_____ Start date _____ Start date _____
_____ Start date _____ Start date _____

FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (Please circle and say who)

- | | | |
|----------------|------------------|---------------------|
| Heart disease | High cholesterol | High Blood Pressure |
| Diabetes | Stroke | Cancer |
| Kidney disease | Arthritis | Anemia |
| Asthma | Glaucoma | Mental illness |
| Eczema | Epilepsy | Hay fever/Hives |

VACCINE HISTORY (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> DPT (Diphtheria, Pertussis, Tetanus) | <input type="checkbox"/> Tetanus Booster (Usually DT) When? _____ |
| <input type="checkbox"/> Polio injection/Polio oral | <input type="checkbox"/> MMR (Measles, Mumps, Rubella) |
| <input type="checkbox"/> HBV (Hepatitis B) | <input type="checkbox"/> Hepatitis A vaccine |
| <input type="checkbox"/> Other (Flu shot, etc) What and When: _____ | |