FOOTHILLS FAMILY MEDICINE
Your Natural Path to Health

Diana R. Crumrine ND
1416 W Washington St
Boise, ID 83702
208-906-1485
www.myfoothillsfamilymed.com

Detox Program 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

Detoxification Goals

What are the most important goals you would like to achieve during this detox? List as many as you would like in order of importance.

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

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Please list any current diagnoses or health concerns:

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?_____

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

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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_____

TYPICAL FOOD INTAKE

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Water:_____ Coffee:_____ Alcohol:_____