Dr. Susan L. Marra
11782 Sand Point Way NE
Seattle WA 98125
Phone: 206-299-2676 Fax: 206-547-0925

NEW PATIENT INTAKE

PLEASE HELP US PROVIDE YOU WITH A COMPLETE EVALUATION BY TAKING THE TIME TO FILL OUT THIS QUESTIONNAIRE CAREFULLY. ALL OF YOUR ANSWERS WILL BE HELD IN STRICT CONFIDENCE UNLESS OTHERWISE SPECIFIED. IF THERE IS ANYTHING YOU WISH TO BRING TO OUR ATTENTION THAT IS NOT ASKED ON THIS FORM, PLEASE NOTE IT IN THE COMMENTS SECTION. WE APPRECIATE YOUR COOPERATION.

Name: _____ **SS#:**_____

Address:_____

City/State/Zip:_____

Home Phone:_____ **Cell Phone:**_____

DOB:_____ **Age:**_____ **Sex:**_____ **Height**_____ **Weight:**_____**lbs.**

Marital Status:_____ **Partner's Name:**_____

No. of Children:_____ **Children's Ages:**_____

Employer:_____ **Work Phone:**_____

Occupation:_____

Primary Care Physician:_____ **Phone:**_____

Emergency Contact:_____ **Phone:**_____

What is the chief complaint you are seeking treatment for?_____

_____

_____

When did this problem begin?_____

_____

What caused this problem?_____

_____

Have you ever had this problem or a similar problem before?_____

_____

To what extent does this problem interfere with your daily activities?_____

_____

Have you ever received treatment for this problem?_____

_____

When?_____ **By Whom:**_____

What was the Diagnosis/Diagnosies?_____

_____

What were the results of the treatment?_____

_____

Current Medications:_____

_____

Food Allergies:_____

_____

Environmental Allergies:_____

Drug Allergies:_____

Hospitalizations:_____

Significant Trauma:_____

Significant Dental Work:_____

What is your average daily diet?

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Any Dietary Restrictions?_____

How frequently do you engage in the following?

Alcohol:_____

Coffee:_____

Tea:_____

Cigarettes:_____

Tobacco:_____

Recreational Drugs:_____

Exercise:_____

Other:_____

Occupation Stress (Chemical, Psychological)?_____

Rate your stress on a scale of 1 to 10 (10 being very stressful):_____

Are you currently involved in any litigation?_____

Have you traveled outside of the USA?_____

Where:_____ When:_____

How Often:_____

Do you engage in camping and hiking frequently?

Where:_____ When:_____

How Often:_____

PAST MEDICAL HISTORY: (Please check those that apply)

Mumps_____ Whooping Cough_____ Measles_____ Diphtheria_____ Scarlet Fever_____

Nephritis_____ Kidney Dz_____ Pneumonia_____ Heart Murmur_____ Mono_____

Other (Please indicate):_____

IMMUNIZATIONS RECEIVED: (Please check those that apply)

MMR_____ DPT_____ Polio_____ Hib_____ Hep B/C_____ Chicken Pox_____ Pneumococcus_____

Asthma_____ Autoimmune Disease_____

Other (Please indicate):_____

Family History: (Please check those that apply)

Heart Disease_____ Diabetes_____ Cancer_____ High BP_____ Stroke_____ Seizures_____

Asthma_____ Autoimmune Disease_____

Other: (Please indicate):_____
_____
_____
_____

On the following lists, please check all of the symptoms that you are currently experiencing:

FEMALE:		**MUSCULOSKELETAL:**		**SLEEP/ENERGY:**	
Irregular menses		Neck pain/Stiffness		Insomnia	
Painful periods		Shoulder Pain/Stiff		Difficulty Falling Asleep	
Heavy Periods		Back Ache/Pain		Difficulty Staying Asleep	
Clots		Elbow Pain		Poor Sleep Quality	
PMS		Hand Pain		Excess Dreams	
Painful Breasts		Hip Pain		Difficulty Waking	
Breast Lumps		Knee Pain		Energy Drops	
Nipple Discharge		Ankle/Foot Pain		Fatigue On Arising	
Vaginal Discharge		Muscle Aches		Fatigue After Meals	
Vaginal Itching		Muscle Weakness		Fatigue w/o Exertion	
Vaginal Sores		Muscle Cramps		Fatigue Always	
STD		Stiff Joints		Hyperactivity	
Menopause		Swollen Joints		Lethargy	
Excess Libido		Arthritis		Restlessness	
Decreased Libido		Bursitis		Other:	
Other:		Burning Sensation			
		Other:			

MALE:		**MUSCULOSKELETAL:**		**SLEEP/ENERGY:**	
Genital Pain		Nervousness		Easily Stressed	
Genital Itching		Tremors		Apathy	
Impotence		Convulsions		Mood Swings	
Premature Ejaculation		Numbness		Anxiety	
Seminal Emissions		Tingling		Panic Attacks	
Excess Libido		Nerve Pain		Temper	
Decreased Libido		Seizures		Anger	
Blood In Urine		Learning Disabled		Depression	
Frequent Urination		Migraine Headaches		Sadness	
Urgent Urination		Dizziness		Pensive	
Painful Urination		Facial Pain		Difficult w/ Decisions	
Incontinence		Poor Memory		Fearful	
Kidney Stones		Bell's Palsy		Repressed Emotions	
Night Urination		Cloudy Thinking		Predominant Emotion	
Other:		Brain Fog		Other:	
		ADD			
		ADHD			
		Other:			

HEAD & FACE:		**EYES:**		**EARS:**	
Headaches		Poor Vision		Poor Hearing	
Location		Glasses		Hearing Aid	
Throbbing Pain		Night Blindness		Ears Ringing	
Burning Pain		Blind Field		Recur Ear Aches	
Stabbing Pain		Floaters		Recur Infections	
Constant Pain		Eye Pain		Ear Pain	
Intermittent Pain		Eye Ache/Strain		Noise Sensitive	
Dull/Severe Pain		Dry Eyes		Ear Drainage	
Worst Season		Itchy Eyes		Pulsing in Ear	
Worse w/ Menses		Tearing		Other:	
Worse In Hot/Cold Weather		Light Sensitivity			
Worse In Day/Night		Eye Ball Pain			
Aggravated By Smells		Frequent Eye Infections			
Pressure In Head		Optic Neuritis			
Back of Head Pain		Uveitis			
Front of Head Pain		Scleritis			
Crown Pain		Pressure Behind Eyes			
Other:		Other:			

CARDIOVASCULAR:		**RESPIRATORY:**		**INTESTINAL:**	
High BP		Chronic Cough		Excess Thirst	
Low BP		Productive Cough		Never Thirsty	
Fainting		Asthma		Excess Hunger	
Chest Tightness		Wheezing		Never Hungry	
Chest Pain		SOB w/Exertion		Weight Gain	
Heart Palpitations		SOB w/o Exertion		Weight Loss	
Irregular Heartbeat		SOB Lying Down		Food Cravings	
Rapid Heartbeat		Phlegm		Nausea	
Cold Hands		Chronic Bronchitis		Vomiting	
Cold Feet		Chronic Pneumonia		Diarrhea	
Cold Body Temp		Difficulty Breathing		Constipation	
Warm Body Temp		Air Hunger		Blood in Stool	
Swelling in Hands		Other:		Food in Stool	
Swelling in Ankles				Urgent BM	
Sock Imprint on Ankles				Gas	
Other:				Belching	
				Heartburn	
				Stomach Pain	
				Belly Pain	
				Bloating	
				Crave Sugar	
				Crave Carbs	
				Other:	

SKIN & HAIR:		**SKIN & HAIR:**		**SKIN & HAIR:**	
Frequent Colds		Sore Gums		Sore Throat	
Sinus Congestion		Bleeding Gums		Hoarseness	
Sinusitis		Dental Decay		Different Swallowing	
Grinding Teeth		Canker Sores		Lump in Throat	
Nose Bleeds		Jaw Clicking		Cough	
Post Nasal Drip		Unusual Tastes		Itchy Throat	
Nasal Discharge		Bad Breath		Ulcerations	
Loss of Smell		TMJ		Pimples	
Smell of Sensitivity		Frequent Fevers		Oily Hair	
Itchy Nose		Hives		Soft Nails	
Sneezing		Dry Hair		Rarely Sweat	
Pollen Allergy		Oily Skin		Bruise Easily	
Dust Allergy		Excess Skin		Other:	
Animal Dander Allergy		Flushing			
Mold Allergy		Other:			
Other:					

Please list any other problems that you would like to discuss with Dr. Marra below:

INSURANCE:

Dr. Susan L. Marra does not participate with any HMO, PPO, POS, Medicare, Medicaid or any other insurance plans. Her office does not submit insurance claims nor is assignment accepted.
All services rendered are fee for service. You will receive an insurance compliant super-bill to submit to your insurance company if you so desire. It is the patient's responsibility to contact their insurance company to determine what their coverage and limitations are in regards to Naturopathic medicine and out of network medical services.

PAYMENT:

PAYMENT IS EXPECTED AT THE TIME OF SERVICE IN THE FORM OF CASH, CHECK, VISA or MASTERCARD. CHECKS SHOULD BE MADE OUT TO: Dr. Susan L. Marra.

CANCELLATION/LATENESS/NO-SHOW:

ALL APPOINTMENTS WITH DR. MARRA MUST BE CANCELLED **AT LEAST TWO BUSINESS DAYS PRIOR TO THE SCHEDULED VISIT OR A FEE OF 50% OF THE OFFICE VISIT WILL BE CHARGED.** THE SAME APPLIES IF YOU DO NOT SHOW UP FOR YOUR APPOINTMENT. IF YOU ARE RUNNING LATE, PLEASE CALL THE OFFICE TO NOTIFY US AND WE WILL DETERMINE IF YOU ARE ABLE TO KEEP OR RESCHEDULE YOUR APPOINTMENT. THIS ALLOWS DR. MARRA TO BETTER PROVIDE THE CARE THAT IS REQUIRED, AS WELL AS ENSURES FAIRNESS FOR EVERYONE. PATIENTS WHO SCHEDULE AND FAIL TO KEEP THREE APPOINTMENTS, OR GIVES LESS THAN 48 HOURS TO CANCEL THEIR APPOINTMENT IN THE SPAN OF ONE YEAR WILL BE DISMISSED FROM THE PRACTICE. THIS IS TO ENSURE FAIRNESS TO BOTH THE PHYSICIAN AND OTHER PATIENTS NEEDING TO BE SEEN BY DR. MARRA. PLEASE BE MINDFUL OF THE NEEDS OF OTHERS.

PRESCRIPTIONS:

PRESCRIPTIONS WILL NOT BE WRITTEN FOR LONGER THAN A TWO-MONTH SUPPLY. IT IS THE PATIENT'S RESPONSIBILITY TO SCHEDULE AN APPOINTMENT WITH THE PHYSICIAN PRIOR TO THE TWO-MONTH POINT FOR MEDICATION REFILLS AND ADJUSTMENTS. THIS IS A MEDICAL LEGAL ISSUE AND IT IS TO ENSURE YOUR SAFETY AND THE PHYSICIAN'S PROTECTION.

DR.MARRA'S PERSONAL LINE FOR MEDICAL EMERGENCIES:

PLEASE BE MINDFUL THAT **DR. MARRA'S PERSONAL LINE IS FOR MEDICAL EMERGENCIES ONLY.** THESE CALLS WILL INCUR A FEE EACH TIME THAT YOU CALL DR. MARRA AFTER HOURS.
IF YOU HAVE A NON-URGENT QUESTION OR INQUIRY, PLEASE CONTACT THE OFFICE DIRECTLY AT (206) 299-2676. WE WILL DO EVERYTHING WE CAN TO GET BACK TO YOU IN A TIMELY MANNER.
THANK YOU FOR YOUR COOPERATION.

I HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION. THE INFORMATION THAT I HAVE PROVIDED IS TRUE AND ACCURATE TO THE BEST OF MY ABILITY:

Patient's Signature: _____ Date:_____

Parent/Legal Guardian Signature: _____ Date:_____

Parent/Legal Guardian Signature: _____ Date:_____

Physician Signature: _____

Date: _____