EcoMedica

Dr. Susan L. Marra
MS, ND, ABAAHP

17791 Fjord Dr NE, Suite 130
Poulsbo, WA 98370

Tel: (206) 299-2676
Fax: (206) 522-7410

NEW PATIENT INTAKE

PLEASE HELP US PROVIDE YOU WITH A COMPLETE EVALUATION BY TAKING THE TIME TO FILL OUT THIS INTAKE 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. **PLEASE RETURN ALL PAPERWORK AT LEAST A DAY PRIOR TO YOUR SCHEDULED APPOINTMENT**. WE APPRECIATE YOUR COOPERATION.

Name: _____ **SS#:**_____

Address:_____

City/State/Zip:_____

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

Email Address:_____

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 1:_____ **Phone:**_____

Relationship to Patient:_____

Emergency Contact 2:_____ **Phone:**_____

Relationship to Patient:_____

Pharmacy Fax Number: _____

QUESTIONNAIRE

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:_____
(If you require more space, please attach a separate page at the end of the intake)

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?_____

Have you been a frequent (*more than 3x a week***) sushi eater?** _____

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_____ HPV_____

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:

MUSCULOSKELETAL			
Neck pain/ Stiffness		Nervousness	
Shoulder Pain/ Stiff		Tremors	
Back Ache/Pain		Convulsions	
Elbow Pain		Numbness	
Hand Pain		Tingling	
Hip Pain		Nerve Pain	
Knee Pain		Seizures	
Ankle/Foot Pain		Learning Disabled	
Muscle Aches		Migraine Headaches	
Muscle Weakness		Dizziness	
Muscle Cramps		Facial Pain	
Stiff Joints		Poor Memory	
Swollen Joints		Bell's Palsy	
Arthritis		Cloudy Thinking	
Bursitis		Brain Fog	
Burning Sensation		ADD/ADHD	
EYES/EARS			
Poor Vision		Optic Neuritis	
Glasses		Uveitis	
Night Blindness		Scleritis	
Blind Field		Pressure Behind Eyes	
Floaters		Poor Hearing	
Eye Pain		Hearing Aid	
Eye Ache/Strain		Ears Ringing	
Dry Eyes		Recur Ear Aches	
Itchy Eyes		Recur Infections	
Tearing		Ear Pain	
Light Sensitivity		Noise Sensitive	
Eye Ball Pain		Ear Drainage	
Frequent Eye Infections		Pulsing in Ear	

HEAD & FACE	
Headaches	
Crown Pain	
Throbbing Pain	
Burning Pain	
Stabbing Pain	
Constant Pain	
Intermittent Pain	
Dull/Severe Pain	
Worst Season	
Worse w/ Menses	
Worse In Hot/Cold Weather	
Worse In Day/Night	
Aggravated By Smells	
Pressure In Head	
Back of Head Pain	
Front of Head Pain	
RESPIRATORY	
Chronic Cough	
Productive Cough	
Asthma	
Wheezing	
SOB w/Exertion	
SOB w/o Exertion	
SOB Lying Down	
Phlegm	
Chronic Bronchitis	
Chronic Pneumonia	
Difficulty Breathing	
Air Hunger	
Other	

SLEEP/ENERGY			
Insomnia		Mood Swings	
Difficulty Falling Asleep		Anxiety	
Difficulty Staying Asleep		Panic Attacks	
Poor Sleep Quality		Temper	
Excess Dreams		Anger	
Difficulty Waking		Depression	
Energy Drops		Sadness	
Fatigue On Arising		Pensive	
Fatigue After Meals		Difficult w/ Decisions	
Fatigue w/o Exertion		Fearful	
Fatigue Always		Repressed Emotions	
Hyperactivity		Predominant Emotion	
Lethargy		Easily Stressed	
Restlessness		Apathy	

SKIN & HAIR			
Frequent Colds		Sore Gums	
Sinus Congestion		Bleeding Gums	
Sinusitis		Dental Decay	
Grinding Teeth		Canker Sores	
Nose Bleeds		Jaw Clicking	
Post Nasal Drip		Unusual Tastes	
Nasal Discharge		Bad Breath	
Loss of Smell		TMJ	
Smell of Sensitivity		Frequent Fevers	
Itchy Nose		Hives	
Sneezing		Dry Hair	
Pollen Allergy		Oily Skin	
Dust Allergy		Excess Skin	
Animal Dander Allergy		Dry Skin	
Mold Allergy		Sore Throat	
Ulcerations		Hoarseness	

CARDIOVASCULAR	
High BP	
Low BP	
Fainting	
Chest Tightness	
Chest Pain	
Heart Palpitations	
Irregular Heartbeat	
Rapid Heartbeat	
Cold Hands	
Cold Feet	
Cold Body Temp	
Warm Body Temp	
Swelling in Hands	
Swelling in Ankles	
Sock Imprint on Ankles	

INTESTINAL	
Excess Thirst	
Never Thirsty	
Excess Hunger	
Never Hungry	
Weight Gain	
Weight Loss	
Food Cravings	
Nausea	
Vomiting	
Diarrhea	
Constipation	
Blood in Stool	
Food in Stool	
Urgent Bowl Movement	
Gas	

SKIN & HAIR			
Pimples		Difficulty Swallowing	
Oily Hair		Lump in throat	
Soft/Brittle Nails		Cough	
Rarely Sweat		Itchy throat	
Bruise Easily		Flushing	
Other		Other	
Other		Other	

INTESTINAL	
Belching	
Heartburn	
Stomach Pain	
Belly Pain	
Bloating	
Crave Sugar	
Crave Carbs	

FEMALE *(Column below)*		**MALE** (*Column below)*	
Irregular menses		Genital Pain	
Painful periods		Genital Itching	
Heavy Periods		Impotence	
Clots		Premature Ejaculation	
PMS		Seminal Emissions	
Painful Breasts		Excess Libido	
Breast Lumps		Decreased Libido	
Nipple Discharge		Blood In Urine	
Vaginal Discharge		Frequent Urination	
Vaginal Itching		Urgent Urination	
Vaginal Sores		Painful Urination	
STD		Incontinence	
Menopause		Kidney Stones	
Excess Libido		Night Urination	
Decreased Libido		Other	

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

_____

_____

_____

Do you or a family member have Hemochromatosis? _____

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 their coverage and limitations in regards to out of network Naturopathic medical services.

PAYMENT:
Payment is expected at the time of service. We accept cash, check, visa or mastercard. Checks should be made payable to: Dr. Susan L. Marra. Please refer to the Financial Fee Schedule & Responsibility for more information.

CANCELLATION/LATENESS/NO-SHOW:
Please be on time for all appointments (*Office/Video/Phone*). If you have a *Video* or *Phone* appointment, Dr. Marra will call you at your scheduled time. Please also make sure that you're in an area that has proper phone reception.

INITIAL NEW PATIENT APPOINTMENT: Appointment must be cancelled at least **3 business days** prior to the scheduled date or the **FULL AMOUNT WILL BE CHARGED.**
ESTABLISHED PATIENTS: Appointment must be cancelled at least **2 business days** prior to the scheduled follow-up or a **THE FULL AMOUNT WILL BE CHARGED**.
The same applies if you do not show up for your appointment or you cannot complete your consent forms and return them to the office prior to your appointment. If you are running late, please call the office at **(206) 299-2676** to notify us, and we will determine if you are able to keep or reschedule your appoint. 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 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 be filled for 2 months **ONLY** at a time. No other refills will be dispensed until a proper follow up visit (with routine labs) has occurred. This is to protect both you and Dr. Marra, as this is also a medical legal issue. If you require a prescription refill, **please call your pharmacy requesting a refill**. Your pharmacy will fax us. Please allow 24-48 hours for refills to be completed. Please plan appropriately if you are leaving on vacation, or live out of town.

APPOINTMENTS:
For **ALL** subsequent visits, patients are required to have **mandatory routine labs done at least 48 hours before EVERY appointment**. These routine labs are not lab specific or require fasting. All patients are required during their *Video* or *Phone* appointments to provide Dr. Marra with their vitals (Blood Pressure, Pulse, Temperature and Weight).

PHONE CALLS:
In an effort to conserve time and energy when calling the office, **PLEASE LEAVE YOUR NAME, PHONE NUMBER (with area code) and A BRIEF MESSAGE**. All calls will be returned at the end of each business day. Please be mindful when calling the office and Dr. Marra's personal cell phone. Dr. Marra's personal cell phone is for **EMERGENCIES ONLY**. **ALL NON URGENT texts/phone calls to Dr. Marra's cell phone will incur a fee**.We are a highly specialized practice dealing primarily with tick-borne diseases. You must have a primary care doctor. We are not a primary care practice, and encourage you to call your primary care doctor or specialist for needs outside of your treatment. For all non-urgent or non-related treatment questions, please a make a list for Dr. Marra at your visits. Please do not email our office with questions as they will not be answered. It is a HIPAA violation.

I HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION. THE INFORMATION THAT I HAVE PROVIDED IS TRUE AND ACCURATE TO THE BEST OF MY ABILITY:
**(For all minors under the age of 18, we require both parents/guardians to sign and date)*

Patient Signature: _____Date:_____

Parent/Legal Guardian Signature: _____ Date:_____

Parent/Legal Guardian Signature: _____ Date:_____

Physician Signature: _____Date: _____