

Susan L. Marra, MS, ND
Tailored Care and Consulting for Chronic Fatigue, Fibromyalgia and Tick Born
Diseases
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NEW PATIENT INTAKE FORM

Date _____

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 absolutely confidential. 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. THANKYOU.

Name _____ SS# _____

Address _____ City/St/Zip _____

Hm Ph _____ Wk Ph _____ Office Ph _____

DOB _____ AGE _____ SEX _____ HT _____ WT _____

Marital Status _____ # of children _____

Partner's Name _____ Children's Ages _____

Employer _____ Phone _____ Occupation _____

Primary Care Physician _____ Phone _____

Emergency Contact Name _____ Phone _____

What is the chief complaint(s) you are seeking treatment for?

When did this problem begin? What caused it?

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

To what extent does this problem interfere with your daily activities (home, work, social life)?

Have you ever received treatment for this problem?

When? _____ By Whom? _____

What was the diagnosis? _____

What were the results of the treatments? _____

Current Medications _____

Drug Allergies _____

Food Allergies _____

Environmental Allergies _____

Hospitalizations _____

Significant Traumas _____

Significant Dental Work _____

What is your average daily diet?

Breakfast _____

Lunch _____

Dinner _____

Any dietary restrictions? _____

How frequently do you engage in the following:

Alcohol _____

Coffee _____

Tea _____

Cigarettes _____

Tobacco _____

Recreational Drugs _____

Exercise _____

Other _____

Occupational Stress (chemical, psychological)

Rate your stress on a scale of 1 to 10 (10 being most) _____

Are you currently involved in any litigation? _____

Have you traveled outside the US? _____ When? _____

Past Medical History as a child?

Mumps _____ Whooping Cough _____ Measles _____ Diphtheria _____ Scarlet Fever _____

Nephritis _____ Kidney Dz _____ Pneumonia _____ Heart Murmur _____ Mononucleosis _____

Other _____

Immunizations Received: _____ MMR _____ DPT _____ DaPT _____ Polio _____ Hib

_____ Hep B _____ Chicken Pox _____ Pneumococcus _____ Other

Family Hx: _____ Diabetes _____ Cancer _____ High Blood Pressure _____

_____ Heart Dz _____ Stroke _____ Seizures _____ Asthma

_____ Allergies _____ Other

PLEASE CHECK ALL OF THE SYMPTOMS THAT YOU ARE CURRENTLY EXPERIENCING .

Female

Irregular Menses _____
Pnful Periods _____
Heavy/Lt Periods _____
Clots _____
PMS Sx _____
Pnful Breasts _____
Breast Lumps _____
Nipple Discharge _____
Vaginal Discharge _____
Vaginal Itching _____
Vaginal Sores _____
STD _____
Menopause _____
Excess Sex Energy _____
Reduced Sex Energy _____
Other _____

Male

Genital Pn _____
Genital Itching _____
Impotence _____
Premature Ejac _____
Seminal Emissions _____
Excess Sex Energy _____
Penile Discharge _____
Blood in Urine _____
Freq Urination _____
Urgent Urination _____
Difficult Urination _____
Painful Urination _____
Incontinence _____
Kidney Stones _____
Night Urination _____
Other _____

SKIN AND HAIR

Rashes _____
Eczema _____
Hair Loss _____
Dry Skin _____
Brittle Nails _____
Night Sweat _____
Other _____

POLLEN ALLEGY

Aggravated Outdoors _____
Aggravated Windy Days _____
Itchy Eyes _____
Aggravated on Clear Days _____
Aggravated 7-11a.m. _____

Musculoskeletal

Neck stiff/pn _____
Shoulder Stiff/pn _____
Back Ache/Stiff/Pn _____
Elbow Stiff/Pn _____
Hand/Wrist Pn _____
Hip Pn _____
Knee Stiff/Pn _____
Foot/Ankle Pn _____
Muscle Aches _____
Muscle Weakness _____
Muscle Cramps _____
Stiff Joints _____
Swollen Joints _____
Arthritis _____
Bursitis _____
Other _____

NEUROLOGICAL

Nervousness _____
Tremors _____
Convulsions _____
Numbness _____
Tingling _____
Nerve Pain _____
Seizures _____
Learning Disabled _____
Migraines _____
Dizziness _____
Facial Pain _____
Poor Memory _____
Bells Palsy _____
Cloudy Thinking _____
Confusion _____
Brain Fog _____
Other _____

Itching _____
Hives _____
Dry Hair _____
Oily Skin _____
Excess Sweat _____
Flushing _____

DUST ALLERGY

Aggravated Indoors _____
Aggravated AC _____
Aggravated by Dust _____
Aggravated by Cold Air _____
Aggravated w/Furnace _____

Sleep/Energy

Insomnia _____
Dif falling asleep _____
Dif Staying Asleep _____
Poor Qual Sleep _____
Excess Dreams _____
Difficulty Waking _____
Energy Drops _____
Fatigue on Arising _____
Fatigue after Meals _____
Fatigue w/o Exertion _____
Fatigue always _____
Hyperactivity _____
Lethargy _____
Restlessness _____
Other _____

EMOTIONAL

Easily Stressed _____
Apathetic _____
Mood Swings _____
Anxiety _____
Panic Attacks _____
Temper _____
Angry _____
Irritable _____
Manic _____
Depressed _____
Sad _____
Pensive _____
Dif w/Decisions _____
Fearful _____
Repress Emotions _____
Other _____
Predominant Emotion _____

Ulcerations _____
Pimples _____
Oily Hair _____
Soft Nails _____
Rare Sweat _____
Bruise Easy _____

MOLD ALLERGY

Aggravated 4-8pm _____
Aggravated Cool Air _____
Aggravated by Damp _____
Aggravated Mowing _____
Aggravated Summer _____

Improves in AC _____
Increased in Cool Air _____
Increased in AC _____
Runny Nose _____
Other _____

Improves Outdoors _____
Increased in bed _____
Increase Winter _____
Runny Nose _____
Other _____

Aggravated Winter _____
Aggravated Fall _____
Runny Nose _____
Other _____

HEAD AND FACE

Headaches _____
Location _____
Throbbing Pn _____
Burning Pn _____
Stabbing Pn _____
Constant Pn _____
Intermittent Pn _____
Dull/Severe Pn _____
Worst Season _____
Worse w/Menses _____
Worse in Hot/Cold _____
Worse at Night/Day _____
Aggravated by Smells _____
Other _____

EYES

Poor Vision _____
Glasses _____
Night Blindness _____
Blind Field _____
Floaters _____
Eye Pn _____
Eye Strain _____
Dry Eyes _____
Itchy Eyes _____
Tearing _____
Light Sensitivity _____
Other _____

EARS

Poor Hearing _____
Hearing Aids _____
Ears Ringing _____
Recur Ear Aches _____
Recur Infections _____
Ear Pn _____
Noise Sensitive _____
Ear Drainage _____
Other _____

NOSE

Frequent colds _____
Sinus Congestion _____
Sinusitis _____
Grinding Teeth _____
Nose Bleeds _____
Post Nasal Drip _____
Nasal Discharge _____
Loss of Smell _____
Smell Sensitivity _____
Itchy Nose _____
Sneezing _____
Other _____

MOUTH

Sore Gums _____
Bleeding Gums _____
Dental Decay _____
Canker Sores _____
Jaw Clicking _____
Unusual Tastes _____
Bad Breath _____
Other _____

THROAT

Sore Throat _____
Hoarseness _____
Dif Swallowing _____
Throat Lump _____
Cough _____
Itchy Throat _____
Other _____

CARDIOVASCULAR

High BP _____
Low BP _____
Fainting _____
Chest Tightness _____
Chest Pn _____
Hear Palpitations _____
Irregular Heartbeat _____
Rapid Heartbeat _____
Cold Hands/feet _____
Cold Body Temp _____
Warm Body Temp _____
Swelling Hands _____
Swelling Ankles _____
Other _____

RESPIRATORY

Chronic Cough _____
Coughing Blood _____
Asthma _____
Wheezing _____
SOB w/exertion _____
SOB w/o exertion _____
SOB lying down _____
Phlegm _____
Chronic Bronchitis _____
Chronic Pneumonia _____
Difficulty Breathing _____
Other _____

INTESTINAL

Excess Thirst _____
Never Thirsty _____
Excess Hunger _____
Never Hungry _____
Wt Gain _____
Wt. Loss _____
Food Cravings _____
Nausea _____
Vomitting _____
Diarrhea _____
Constipation _____
Blood in Stool _____
Food in Stool _____
Urgent BM _____
Hemorrhoids _____
Gas _____
Belching _____
Heartburn _____

Stomach Pn _____
Belly Pn _____
Bloating _____
Other _____

Comments: Please tell us any other problems you would like to discuss.

Susan L. Marra, MS, ND does not participate with any HMO, PPO, POS, Medicare or insurance plans. We do not submit insurance claims nor is assignment accepted. All services rendered are fee for service. You will receive a superbill to submit to your insurance company.

PAYMENT IS EXPECTED IN FULL AT THE TIME OF SERVICE IN THE FORM OF A CHECK OR CASH. Checks should be made out to Dr. Susan L. Marra. Patients may submit the bill provided to their insurance company for reimbursement according to the limits of the policy if they have out of network benefits. It is the patient’s responsibility to contact their insurance company to see what their coverage and limitations are in regards to naturopathic medicine and out of network medical services.

FEES:

First office Visit	\$340.00
(this does not include any lab work or supplements)	
Second Office Visit	\$260.00
Follow up Visit	\$225.00
Phone Consult	\$150.00 (patient phones the doctor)
Letters	\$200/hour
Photocopy	\$00.40/page plus postage

ALL APPOINTMENTS MUST BE CANCELLED WITHIN 48* HOURS OF THE SCHEDULED VISIT OR A FEE OF 50% OF THE OFFICE VISIT WILL BE CHARGED. THIS IS TO INSURE FAIRNESS TO BOTH THE PHYSICIAN AND OTHER PATIENTS. PLEASE BE MINDFUL OF THE NEEDS OF OTHERS.

PRESCRIPTIONS WILL NOT BE WRITTEN FOR MORE THAN TWO MONTHS. IT IS THE PATIENT’S RESPONSIBILITY TO SCHEDULE AN APPOINTMENT WITH THE PHYSICIAN PRIOR TO THE TWO MONTH POINT FOR MEDICATION REFILLS. THIS IS A MEDICOLEGAL ISSUE. IT IS TO ENSURE YOUR SAFETY AND THE PHYSICIAN’S PROTECTION.

I have read and understand the above financial information regarding fees and office rules of this office and I fully agree to abide by them.

Patient’s/Legal Guardian Signature: _____
Date _____

Physician Signature: _____
Date _____