



Susan L. Marra MS, ND

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 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. THANK YOU.

Name _____ SS# _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

DOB _____ Age _____ Sex _____ Height _____ Weight _____

Marital Status _____ # of Children _____ Children's Ages _____

Partner's Name _____

Employer _____ Phone _____

Occupation _____

Primary Care Physician _____ Phone _____

Emergency Contact Name _____ Phone _____

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

When did this problem begin? _____

What caused the problem? _____

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

11782 Sand Point Way NE, Seattle WA 98125
tel: (206) 299-2676 fax: (206) 547-0925
email: info@drsusanmarra.com



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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/Diagnoses _____

What were the results of the treatments? _____

Current Medications _____

Food Allergies: _____

Environmental Allergies: _____

Drug Allergies: _____

Hospitalizations _____

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Significant Trauma's _____

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 _____



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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 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 _____

Immunizations Received:

Please check those that apply.

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MMR _____ DPT _____ Polio _____ Hib _____ Hep B/C _____ Chicken Pox _____ Pneumococcus _____

Other: _____

Family History:

Please check those that apply.

Heart Disease _____ Diabetes _____ Cancer _____ High BP _____ Stroke _____ Seizures _____

Asthma _____ Autoimmune Disease _____

Other: _____

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		diff falling asleep	
heavy periods		back ache/ pain		diff staying asleep	
clots		elbow pain		poor sleep quality	
PMS		hand pain		excess dreams	
pnful 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	

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FEMALE:		MUSCULOSKELETAL:		SLEEP/ENERGY:	
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 ejac		numbness		anxiety	
seminal emissions		tingling		panic attacks	
excess libido		nerve pain		temper	
decreased libido		seizures		anger	
blood in urine		learning disabled		irritable	
freq urination		migraine HA		manic	
urgent urination		dizziness		depression	
difficulty urinating		facial pain		sadness	
pnful urination		poor memory		pensive	
incontinence		Bell's palsy		Dif w/ Decisions	
kidney stones		cloudy thinking		fearful	
night urination		brain fog		repressed emotions	
Other:		sensory overload		other	
		ADD		predominant emotion	
		ADHD			
		Other:			

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HEAD AND 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 with menses		tearing		Other:	
worse in hot/cold		light sensitivity			
worse in day/night		eye ball pain			
aggravated by smells		freq 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		wt gain	
heart palpitations		SOB w/o exertion		wt loss	
irregular heartbeat		SOB lying down		food cravings	

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CARDIOVASCULAR:		RESPIRATORY:		INTESTINAL:	
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 AND HAIR:		SKIN AND HAIR:		SKIN AND HAIR:	
frequent colds		sore gums		sore throat	
sinus congestion		bleeding gums		hoarseness	
sinusitis		dental decay		diff swallowing	
grinding teeth		canker sores		lump in throat	
nose bleeds		jaw clicking		cough	
post nasal drip		unusual tastes		itchy throat	
nasal discharge		bad breath		Other:	
loss of smell		TMJ			
smell sensitivity		Other:			

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SKIN AND HAIR:		SKIN AND HAIR:		SKIN AND HAIR:	
itchy nose					
sneezing					
pollen allergy					
dust allergy					
animal dander allergy					
mold allergy					
Other:					

SKIN AND HAIR:		SKIN AND HAIR:		SKIN AND HAIR:	
rashes		freq fevers		ulcerations	
eczema		hives		pimples	
hair loss		dry hair		oily hair	
dry skin		oily skin		soft nails	
brittle nails		excess sweat		rarely sweat	
night sweats		flushing		bruising easily	
freq fevers		Other:			

COMMENTS:

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



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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.

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.

Patients may submit the super-bill provided to the 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 determine what their coverage and limitations are in regards to Naturopathic medicine and out of network medical services.

ALL APPOINTMENTS WITH DR. MARRA MUST BE CANCELLED WITHIN 48 HOURS PRIOR TO 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 NEEDING TO BE SEEN BY DR. MARRA. PLEASE BE MINDFUL OF THE NEEDS OF OTHERS. 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 MEDICO LEGAL ISSUE. IT IS TO ENSURE YOUR SAFETY AND

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THE PHYSICIAN'S PROTECTION. I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION, AND THE INFORMATION THAT I HAVE PROVIDED IS TRUE AND ACCURATE TO THE BEST OF MY ABILITY.

Patient's Signature _____ Date _____

Print Name _____

Parent/Legal Guardian Signature _____

Parent/Legal Guardian Signature 2 _____

Physician's Signature _____ Date _____