Katja Magus, ND
5825 221st Pl Se Ste 204
Issaquah WA 98027

Date: ______________________

Name: ____
(First) (Middle) (Last)

Address: ____

Date of Birth: ________________ Age: ______ Gender: ______ Email: ____________________________

Cell Phone: ____________________ Home phone: ______________ Ok to leave a message?______

Emergency Contact:

Name: ______________________ Relationship: ________________ Phone number: ________________

How did you hear about Alpine Acupuncture?

Why did you choose to see Dr. Katja Magus today?

PERSONAL AND FAMILY HEALTH HISTORY					
Condition	Relation/ Self	C = Current P = Past	Condition	Relation/ Self	C = Current P = Past
Alcoholism			Drug addiction		
Alzheimer's			Epilepsy/ seizures		
Anemia			Glaucoma		
Arthritis			Gout		
Attention deficit			Heart Disease		
Bleeding disorders			Kidney Disease		
Blood pressure ↑/↓			Liver Issues		
Cancer			Lung Issues		
Cholesterol ↑/↓			Mental Illness		
Chronic fatigue			Parkinson's		
Crohn's disease			Skin issues		
Depression			Tuberculosis		
Diabetes			Ulcerative colitis		
Other medical conditions or symptoms that run in your family?					
Hospitalizations, surgeries, serious illnesses, injuries, motor vehicle accidents:					
Number and types of alcoholic beverages per week:					
Smoking: ☐ Current ☐ Past ☐ Never	For how long:		How many per day:		

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REVIEW OF SYSTEMS

1 = mild or occasional   2 = moderate   3 = severe or frequent   P = Past

General

_______ Frequent illness
_______ Unexplained weight loss/gain
_______ Fever/Chills
_______ Night sweats
_______ Allergies

Head

_______ Headaches
_______ Head injuries
_______ Dizziness

Ears/Eyes/Nose/Throat

_______ Hearing changes
_______ Ear infections
_______ Ringing in the ears
_______ Loss of balance
_______ Dry eyes
_______ Vision changes
_______ Dark eye circles
_______ Cataracts
_______ Itchy eyes
_______ Conjunctivitis
_______ Loss of smell
_______ Sinus issues
_______ Seasonal allergies
_______ Nose bleeds
_______ Hoarse voice
_______ Sore tongue
_______ Cold sores
_______ Loss of taste
_______ Goiter
_______ Difficulty swallowing

Respiratory

_______ Coughing
_______ Wheezing
_______ Sputum
_______ Shortness of breath
_______ Snoring
_______ Asthma

Cardiovascular

_______ Rapid heart rate
_______ Irregular heart rate
_______ Fainting
_______ Stroke
_______ Chest pain
_______ Legs hurt after walking
_______ Varicose veins
_______ Cold hands and feet

Gastrointestinal

_______ Abdominal pain
_______ Reflux/heartburn
_______ Loose stools
_______ Constipation
_______ Vomiting
_______ Nausea
_______ Gas
_______ Bloating
_______ Hemorrhoids
_______ Anal itching
_______ Greasy food upsets
_______ Shaky if hungry
_______ Emotional eating
_______ Fatigue/irritability better eating

Genitourinary

_______ Frequent urination
_______ Difficulty urination
_______ Urinary infections
_______ Urinary incontinence
_______ Wakes more than once to urinate during sleep
_______ Hernias
_______ Prostate enlargement
_______ Erectile difficulty
_______ Low libido
_______ Currently sexually active (Y/N)
_______ Sexual orientation: M/F/(B)oth/(O)ther

Musculoskeletal

_______ Joint pain
_______ Muscle pain
_______ Chronic tension
_______ Muscle weakness
_______ Broken bones
_______ Osteoporosis

Skin

_______ Itching
_______ Dry skin
_______ Acne
_______ Skin tags
_______ Nail issues
_______ Dandruff
_______ Thinning hair

Neurological

_______ Loss of sensations
_______ Numbness, tingling
_______ Increased sensitivity to pain
_______ Unintentional movements

Mental/Emotional

_______ Anxiety
_______ Excessive worrying
_______ Chronic tension
_______ Chronic stress
_______ Irritability
_______ PTSD/Abuse
_______ Depression
_______ Mental/emotional fog
_______ Treated for mental emotional issues
___ Little interest in doing things
___ Feeling down or helpless

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FEMALE REPRODUCTIVE

Menopause: ☐Yes, age: ☐No ☐Perimenopausal	Number of pregnancies:	Cycle length (i.e. 28 days):
	Number of live births:	Days heavy: moderate: light: Total:
☐Pregnant ☐Nursing ☐Trying to conceive	Number of miscarriages:	
	Number of abortions:	Cycles: ☐regular ☐irregular ☐Spotting between periods
Do you do self breast exams? ☐No ☐Yes, how often:	Number of living children:	
	Birth control methods:	

1 = mild or occasional 2 = moderate 3 = severe or frequent P = Past

____	Painful menses	____	Irritability	____	Hot flashes	____	Nipple discharge
____	Breast tenderness	____	Bloating	____	Vaginal dryness		Difficulty w/ conceiving pregnancy, or delivering
____	Mood changes	____	Headache	____	Endometriosis		
	Weight gain		Crave sweets/carbs		Ovarian cyst		

SLEEP AND ENERGY

What time do you go to bed?		What time do you wake up?	
How soon before falling asleep?		Need an alarm to wake up?	
Difficulty falling asleep?		What time do you feel awake?	
Need sleep aids?		Wake refreshed?	
Difficulty staying asleep?		Need coffee or tea to wake?	
Restless sleep?		Tired all day?	
Sleep apnea?		Afternoon fatigue?	
Dream most nights?		Evening person?	
Hours of sleep per night?		Tired no matter how much you sleep?	
How many times do you wake up during the night?		Fall asleep during the day when sitting?	

NUTRITION

Diet restrictions/food sensitivities (ex: beef, dairy, gluten, salt, shellfish, nuts, etc):

What do you drink other than water (coffee, tea, juices, soda, etc):

Typical Breakfast:	Lunch:	Dinner:

MEDICATION AND SUPPLEMENT LIST

(Prescription medications, contraceptives, over the counter medications, nutritional supplements, herbs, etc)

Name of Product	Brand	Dose/Frequency	How long?

What else would you like me to know about you and your health?

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Consent for treatment

I hereby consent to receive care from Dr. Katja V. Magus, ND:

- Naturopathic lifestyle, exercise, and nutritional counseling.
- Biofeedback, mediation and stress/relaxation advice.
- Herbal medicine and therapeutic nutrients.

I read and understood the following:

- ☐ Dr. Katja Magus does not offer primary care. If you need help finding a naturopathic physician who specializes in primary care we can help you find a great doctor here in town.
- ☐ Treatments with Dr. Magus may have a positive impact on your physical health, but are not intended as primary treatments for your physical health conditions.
- ☐ Treatments with Dr. Magus may be synergistic to mental health treatments you may be receiving but are not intended as treatments for any mental health conditions.

Agreement By The Patient / Guarantor To Be Financially Responsible For Fees

I, _____________________________, (patient or guarantor) understand that Dr. Katja Magus is an out of network provider, and as such, does not accept insurance at the time of visit. She is willing to provide a paper superbill for insurance billing upon request, but there is no guarantee of payment as each insurance company reimburses differently. I understand that I am financially responsible for all charges whether or not paid by my insurance. I am aware that some and perhaps all of the services provided may be non-covered services under my insurance. I also understand that a monthly interest rate of 1.5% will be applied to any unpaid balance over 30 days past due. ***Initial:***________

Agreement By The Patient Regarding Cancelled/Missed Appointments

Patient understands that a missed appointment (No Show) will result in full charges being issued for that appointment. If a patient fails to give the clinic 24 hours notice of a change of appointment, the patient may be charged for that appointment. You may change your appointment online or over the phone. ***Initial :***______

Medical Release To Insurance Company & Referring Physicians

I authorize the release of medical information to my insurance company / companies and/or primary physician, including diagnosis and the record of treatment or examinations rendered to me during the period of such medical care. ***Initial:*** ________

Notice Of Privacy Practices – Acknowledgement

- ❖ We keep a record of the health care services we provide you.
- ❖ You may ask to see and copy that record.
- ❖ You may also ask to correct that record.
- ❖ We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so.
- ❖ You may see your record or get more information about it by contacting the Office Manager / HIPAA Officer.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. You acknowledge that you have been provided with a copy of our Notice of Privacy Practices to read.
Initial: ________

____ ______________
Patient or legally authorized individual signature Date

____ ___________________
Printed name and signed on behalf of the patient Relationship (Parent, legal guardian, representative)

____
Witness/Staff Member