Holistic Breast Specialist™ & Naturopathic Doctor
DEIKA KING

WOMEN WELLNESS

14526 Old Katy Rd. Ste. 108 Houston, TX 77079 832-422-7271

Women's Wellness

Name: _____ D.O.B. _____

Address: _____

City: _____ ST: _____ Zip: _____

Phone: _____(Home) _____(Cell)

E-mail: _____ Occupation: _____

How did you find out about us? _____

PLEASE READ THE FOLLOWING AND SIGN BELOW:

BRAS Thermography uses a Meditherm Digital Infrared Thermal Imaging camera to provide a 15-minute non-invasive test of physiology. DITI detects the minute physiologic changes that accompany breast pathology.

I understand that BRAS Thermography does not provide a medical diagnosis, but simply acts as the clinical Thermographer-transmitting digital pictures to EMI, a medical digital infrared thermal imaging service. An M.D. will interpret the images and return the images to BRAS. This evaluation may suggest further medical testing. If further testing is suggested I will consult my physician or health care provider. A doctor to doctor consultation can be arranged between Meditherm and your doctor if necessary.

I give my permission for the Clinical Thermographer at BRAS to take and submit DITI pictures for interpretation. I understand that by doing so, the Clinical Thermographer is not becoming my primary care physician. I understand that my thermography report will be emailed to me so that I can share with my health care practitioner or primary care doctor.

Referring Physician's Name: _____

Client Signature_____ Date_____

Thermographer's Signature_____ Date_____

All Clinical Thermographers are trained and certified by the ACCT.

Current Complaint: _____ **DOB:** _____

Significant Past Illnesses:

Illness	*Year(s)*	*Comments*

Previous Surgery:

Type of Surgery	*Year(s)*	*Comments*

Present Health Problems *(please indicate current concerns and/or symptoms)*:

Medical Problem	*Date of Onset*	*Comments/Concerns/Symptoms*

Present Medications or Supplements:

Medication Name	*Taken For*	*Date Started*

Family Medical History:

	Age if Living	Age at Death	Cause of Death	Major Medical Health Problems (Bubble in all that apply)
Mother				① Breast Cancer ① Cancer ① Stroke ① Heart Attack/MI ① Hypertension ① Other (specify):_____
Father				① Breast Cancer ① Cancer ① Stroke ① Heart Attack/MI ① Hypertension ① Other (specify):_____

Do you participate in regular *(annual/bi-annual)* dental visits? ① Yes ① No

Any major dental work? _____

General overall health currently: ① Excellent ① Good ① Fair ①Poor

If *fair* or *poor*, please explain: _____

_____

Other Current Treatments: _____

_____

Extended Breast Questionnaire

Have you ever been diagnosed with breast cancer? Yes _____ No_____

Type of Cancer	***Date of Dx***	***Presently Being Treated***
Metastatic	Mo Yr	
Local	Mo Yr	
Lymph node involvement	Mo Yr	

Where on the breast *(upper outer, upper inner, lower outer, lower inner)***:**

Left Breast	UO	UI	LI	LO
Right Breast	UO	UI	LI	LO
Treatment	Surgery _____	Chemo _____	Radiation ___	None _____

Diagnosed with breast disease: Yes____ No____ *If yes, please check **Type of Disease** below:*

Fibrocystic ___	Cystic _____	Mastitis _____	Abscess _____	Other_____

Breast biopsies or surgery *(upper outer, upper inner, lower outer, lower inner)***:**

Left Breast	UO	UI	LI	LO	Nipple
Right Breast	UO	UI	LI	LO	Nipple

Please explain any past or current treatment for breast disease:_____

_____

Breast Thermography Confidential Questionnaire

Please answer all questions	*Yes*	*No*
1. Do you have any close relative who has had breast cancer? Whom? _____		
2. Have you ever been diagnosed with breast cancer?		
3. Have you ever been diagnosed with any other breast disease (fibrocystic)?		
4. Have you had any biopsies or surgeries to your breasts?		
5. Have you had any breast cosmetic surgery or implants?		
6. Have you had a mammogram in the past 12 months?		
7. Have you had a mammogram in the past 5 years?		
8. Have you had abnormal results from any breast testing?		
9. Have you ever taken a contraceptive pill for more than 1 year? If yes, are you still taking a contraceptive pill? _____		
10. Have you suffered with cancer of the womb?		
11. Have you had pharmaceutical hormone replacement therapy?		
12. Do you have an annual physical examination by a doctor? Does this include a gynecological exam? _____		
13. Do you perform a monthly breast self-exam?		

14. How many mammograms have you had in total? _____
15. What was your age when you had your first mammogram? _____
16. How many births have you had? _____ **Your** age at the birth of your first child? _____
17. Did your periods start before the age of 12? _____; Or finish after the age of 50? _____
18. Smoker status? ① Yes ① Never ① Not in last 12 months ① Not in last 5 years

Have you recently had any of these breast symptoms?	*Right Breast*	*Left Breast*
Pain		
Does pain subside after menstrual cycle ends		
Tenderness		
Does tenderness subside after menstrual cycle ends		
Lumps		
Change in breast size		
Does change in breast size subside after menstrual cycle ends		
Areas of skin thickening or dimpling		
Secretions of the nipple		

HEAD & NECK

Please answer all questions	*Yes*	*No*
1. Do you suffer with headaches? If yes, how often _____		
2. Do you have allergies?		
3. Do you have TMJ or does your jaw click?		
4. Do you currently have a cold?		
5. Are you being treated for a thyroid disorder?		
6. Do you have neck pain?		
7. Do you have upper back pain?		
8. Do you have a history of carotid artery disease? If yes, who? _____		
9. Do you have a family history of stroke? If yes, who? _____		
10. Do you currently suffer with sinus problems?		

Do you have any special concerns or are there any details related to the information above?

CHEST, HEART & LUNGS

Please answer all questions	*Yes*	*No*
1. Have you been diagnosed with? Heart disease ____ Lung disease ____ Upper spine disorders ____		
2. Do you suffer with upper back pain?		
3. Do you suffer with chest pain?		
4. Have you ever had surgery to your? Heart ____ Lungs ____ Mid to upper back ____		
5. Do you have asthma or shortness of breath?		
6. Do you currently smoke?		
7. Have you smoked in the past 5 years?		

Do you have any special concerns or are there any details related to the information above?

LOWER ABDOMENT & LOWER BACK

Please answer all questions	*Yes*	*No*
1. Do you suffer with acid reflux?		
2. Do you have pain in the? Stomach _____ Below the right breast _____ Below the left breast ____ Abdomen _____ Lower back _____		
3. Have you had surgery or disease in the? Stomach _____ Spleen – left upper quadrant ____ Kidneys _____ Spleen – right upper quadrant ____ Intestines ____ Intestines ____ Abdomen _____ Lower back _____		

Do you have any special concerns or are there any details related to the information above?

HANDS & ARMS

Please answer all questions	*Yes*	*No*
1. Do you suffer with pain in the: Left Shoulder _____ Right Shoulder _____ Left Elbow _____ Right Elbow _____ Left Arm _____ Right Arm _____ Left Hand _____ Right Hand _____		
2. Have you had surgery to: Left Shoulder _____ Right Shoulder _____ Left Elbow _____ Right Elbow _____ Left Arm _____ Right Arm _____ Left Hand _____ Right Hand _____		
3. Have you ever been diagnosed with diabetes?		

Do you have any special concerns or are there any details related to the information above?

PATIENT DISCLOSURE

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic findings discussed in the Report.

By signing below, I certify that I have read and understand the statements above and consent to the examination.

Patient Signature _____ Today's date _____

Which of the following do you have concerns about and/or want more information about (for you or a family member)?

__ Brain Health	__ Cellulite	__ Cleansing	__ Hormone Balancing	__ Immune Boosting
__ Insomnia	__ Memory	__ Neuropathy	__ Quit Smoking	__ Skincare
__ Exercise	__ Mood	__ Stress Relief	__ Weight Loss	__ Thyroid

Do you have any additional concerns?

_____
_____
_____
_____

Authorization to Use or Disclose Protected Health Information

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, ***Deika King, Naturopath,*** **may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.**

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**
For the specific purpose of (*describe in detail*): **Interpretation of said images**

Effective dates for this authorization_____/_____/_____ through _____/_____/_____. This authorization will expire at the end of this period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance in the use or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient's Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility of benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____
Signature of Patient or Patient's Authorized Representative *Date*

_____ _____
Authorized Signature of Facility *Date*

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DEIKA KING

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www.DeikaKingND.com

NEW THERMOGRAPHY CLIENT INFORMATION

Thank you for choosing us your Thermography screening. Our goal is to work with you in getting to the "root cause" of your problem. We do our best to make your experience a rewarding one and your feedback is welcomed.

Please take some time to go over these forms and sign where appropriate. Once completed you have the option of emailing them, faxing them or dropping them off at our office. **All documents must be *completed* when you arrive for your thermography appointment.**

If you choose to email or fax, please call our office to confirm the receipt of your documents.

If any additional information is necessary, you will be called prior to your scheduled appointment.

Tel. Number: 832-422-7271
Fax Number: 713-904-2477
Email Address: info@deikakingnd.com

Love & Health,

Deika King, TND, MH, CCT. PSc.D
Holistic Breast Specialist & Naturopathic Doctor

Welcome

The Owner:

Deika King is a Traditional Doctor of Naturopathy, Master Herbalist, Clinical Thermographer, Health Coach, Integrative Cancer Educator, Doctor of Pastoral Medicine, and Registered Natural Health Practitioner. She specializes in women's breast health and Naturopathic health restoration.

At your Functional Breast and Body Screening:

You will be required to fill out an assessment specific to the type of appointment you scheduled. You will be required to allow a minimum of 60 minutes for your first appointment and at least 30 minutes for your follow up appointments. Appointments may run longer based on your need and available time. Please make sure that you arrive promptly to your appointment. We request that if you are running late that you call the office and inform us. ***We require that your assessment be completed when you arrive to our office for thermography screening. Please see our cancellation policy prior to confirming your first appointment.***

Office Fees:

Our office fees are based on the services and time you required with your practitioner. Please call our office or visit our website for specific office fees for services offered.

Payment:

We are not able to accept insurance, but we will accept Health Savings Accounts, Flex Plans or Cafeteria Plans for Thermography Scans. A credit card on file is required to book an appointment, but will only be charged based on office policies.

- **All appointments require a 30% reservation fee. This fee will be applied to services rendered on day of appointment and will be paid at time the appointment is scheduled.**
- **Appointments cancelled within 48 hours will be refunded their reservation fee.**
- **No show or late cancellations will be charged the Full Cost of the Thermography appointment.**

Note: If for any reason, we are not able to obtain payment for missed appointment, or late cancellation with credit card on file; you will not be able to schedule another appointment until all previous payments are paid in full.

****** To provide better service to our clients, we do not overbook to compensate for no shows; your appointment time is dedicated only to you, therefore, we must bill for missed appointment. We pride ourselves in not having our clients wait 30 minutes before being seen and then spending only 5 minutes as one would experience in a Medical Doctors office. Please be considerate of our time and prep time to see you******

PATIENT PRESCREENING INFORMATION

Please comply in order to receive the most accurate reading for your scans.

3 Months Prior

No major surgery in area being imaged
No radiation therapy
Women: cease pregnancy, lactation and breastfeeding

1 Month Prior

No minor surgery to area being imaged, i.e. biopsy

1 Week Prior

Avoid strong sunlight or tanning session (especially sunburn)

24 Hours Prior

No treatment: chiropractic, mammogram/x-ray, acupuncture, massage, dialysis, physical therapy, electrical muscle stimulation, steam room, sauna, hot or cold pack use.

Day of the Exam

No lotions, powders, or oils on the areas being imaged
No make-up on face or neck
No deodorant or antiperspirant
No shaving of areas to be imaged

2 Hour Prior

No smoking
No exercise
No stimulants - caffeine, tea, chocolate, alcohol

1 Hour Prior

No bathing
No hot or cold food or beverages (room temp is fine)

What to Wear

Loose fitting clothes
No jewelry
Hair should be pinned up (we have hair accessories to keep your hair up, if you forget)
No underwire bra

What to Bring

Intake form and other documents requested for your screening. You may bring in other screening results (mammogram, ultrasound, biopsy, etc.) that relates to your screening.

ABOUT THE VISIT – OUR PROCESS

When you arrive to your office, we will review your intake forms and any document related to your screening. We may ask you to clarify information on your intake form and we will discuss any concerns you have about either your health or your screening. We will discuss the screening process and get you settled in. You will need to sit long enough to have your body get adjusted to the room temperature before we begin screening. You will be asked to undress based on the type of screening you have scheduled. You will be given directions on positioning for best image results.

Once imaging is completed, we will review the images and discuss them with you. If you are schedule for screening that involves the breast, we will provide you with a breast health prevention booklet and we will review the booklet with you. This is designed to educate client on ways to keep their breast healthy.

WHO TAKES THE IMAGES?

You screening will be performed by Deika King. Deika King is not a medical doctor. She is Level II Certified Clinical Thermographer, Traditional Doctor of Naturopathy, Master Herbalist and Integrative Cancer Educator. She received her thermography screening education through the American College of Clinical Thermology (ACCT) which is associated with Duke University.

WHO PREPARES THE REPORTS?

Our reports are interpreted by a series of medical doctors trained in the study of thermology. These are licensed medical doctors that are required to have continued their education in thermology over the years. To create your report, our interpreting doctors need to consider the information in your intake form, which is why it is important that we review it prior to screening. The doctors write their interpretation in what we call a Report of Findings, which is helpful for your practitioner in designing a health protocol plan specific to your needs.

RECEIVING YOUR RESULTS

All reports will be received electronically between 2-3 days. You will receive the interpreting doctor's report along with images. If you need your report within 24 hours, we are able to provide urgent reporting for a fee of $50. Once you have received your report, we are more than happy to review those with you within 2 weeks of receiving it at no charge. To schedule a phone report review, you will need to visit our website www.DeikaKingND.com under book online to schedule your thermography report review. Anything passed 2 weeks will incur a thermography consultation fee of $50 (15 min.) or $90 (30 min.)

SERVICE OPTIONS

- *** Breast – Initial and Annual - $215**
- *** Women's Wellness - $340**
- *** Region of Interest - $190**
- *** Breast Baseline (3mths) - $165**
- *** Full Body Scan - $470**
- *** Child Region of Interest - $190**
- *** Breast Baseline Package (initial & 3mth scan) -$515**
  Includes: 1st and 2nd scan, breast risk assessment, breast consultation (1hr), Non-invasive assessment, 2-BioMat Detox Sessions, Prevention Education and Booklet, Toxicity Assessment, 10-Day mini eCourse, Scarf, Dry Brush and 1 Supplement.
- *** Comprehensive Package (initial, 3mth and annual scan) - $835**
  Includes, 1st, 2nd, and Annual thermography breast scans, breast risk assessment, breast consultation (2hrs), Non-invasive assessment, 3-BioMat Detox Sessions, Prevention Education, Toxicity Assessment, 10-Day mini eCourse, Scarf, Dry Brush, Body Composition Analysis, and 3 Supplements.

Initial _____

BREAST HEALTH KIT OPTIONS **(please select one if interested)**

*** Lumpy Breast Kit (women with lumpy breast) - $49**

- Vitamin E cream, Vitamin E Supplement, High potency Liquid Iodine, Breast Exercise Instruction, Alkaline food list (based on the type of lump- it may mean your body is acidic and we want to address that the best possible way)

*** Breast Pro Kit (addresses inflammation) - $47**

- Breast Massage Oil, natural deodorant, high potency liquid iodine, anti-inflammatory list.

*** Breast Care Kit (address breast concerns and lymphatic congestion) -$70**

- Breast massage oil, high potency liquid iodine, vitamin D3, lymphatic dry brush, selenium, breast prevention booklet.

*** If you have cancer and would like something specifically for your situation, we will need specific information about your complete history to be able to design a kit just for you.**

I have read and understand the above information and I accept the policies of B.R.A.S. Thermography & Wellness.

My signature confirms that this information is true.

Signature: _____ **Date:** _____