Deika King, TND, MH, CCT, PSc.D
14526 Old Katy Rd. Ste. 108
Houston, TX 77079
www.deikakingnd.com
info@deikakingnd.com
Tel. 832-422-7271

ACUTE INTAKE FORM

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Sex: M / F Marital Status: M / S/ D/ W

Contact Person in case of Emergency: _____ Phone#: _____

Date of last visit: _____ Reason: _____

Family Physician: _____ Phone #: _____

Past Injuries: _____ When: _____

_____ When: _____

_____ When: _____

Past Surgeries: _____ When: _____

_____When: _____

_____When: _____

Allergies (Please list) : _____

_____

What is your primary reason for visiting us today? _____

_____

Please list foods supplements, vitamins, mineral, homeopathic, and herbs you are currently taking and indicate dosage:

Please list any prescriptions and non-prescription medicine you currently take and indicate dosage:

AGREEMENT AND CONSENT TO CARE

It is our pleasure to provide you with effective and quality wellness. In order to do this, please understand the following policies and procedures:

Fee Schedule:
15-minute consultation - $50
30-minute consultation - $90

THIS IS TO ACKNOWLEDGE That I have been informed and understand:

1. Any advice provided to me as a client of this clinic is not mutually exclusive from any advice that I may now be receiving or may receive in the future from another health care provider.
2. I understand that Naturopathy is a comprehensive approach to health and wellness and focuses on prevention and the use of natural substances and therapies including: Clinical Nutrition, Lifestyle Counseling, Homeopathy, Chinese Medicine, Botanical Medicine, Physical Medicine & Hydrotherapy.
3. I am at liberty to seek and/or continue care from a medical doctor or other qualified health care provider.
4. I am aware that no part of my care is covered by Insurance and that this practice is cash based and I am solely responsible for payment.
5. Payment is to be made at time of service.

I HEREBY AUTHROIZE AND CONSENT TO HOLISTIC CARE BY:
Deika King, TND, MH, CCT, PSc.D _____ (Initial)

I understand and agree to the above policies and procedures:

Client's Full Name (please print): _____

Date of Consent: _____ Signature: _____
(Client or legal guardian)

How did you hear about us? Advertisement / Word of Mouth / Walk-In / Referral /
Other: _____