14521 Old Katy Rd. Ste. 240
Houston, TX 77079
Tel. 832-422-7271
Fax 832-747-6146
www.deikakingnd.com
info@deikakingnd.com

Holistic Breast Specialist™ & Naturopathic Doctor
DEIKA KING

Welcome to the Wellness Practice of Deika King, ND, MS, MH, CCT

Providing: Naturopathy, Nutrition, Thermography, Breast Health, and Holistic Cancer Coaching

Hello,

I have created this welcome letter and initial paperwork packet to make the process a bit easy for us to get to know each other. I imagine you want to be deliberate in your choice of practitioner and as informed as you can be about my approach and practice. Similarly, to give you my fullest attention, I want to spend time with the details of who you are, how you feel, and how you move through life.

As a health and wellness practitioner

- I value collaborating with my clients on creating a care plan
- I believe in each body's ability to heal itself with the proper support
- I believe that clients know their bodies better than anyone and encourage clients to share their perspective with me
- I gather information that helps me to create a care plan that is unique to the individual.
- I value both my own and my client's intuition, as much as lab and assessment values
- I respect the client experience of being both a client and an autonomous person
- I am interested in evidence based info but am more interested in what my clients and I create together.
- I believe that most people are basically healthy and will use a variety of tools to enhance clients' health.

Working with me is effective when you…

- Take primary responsibility for your health
- Are curious about your mind, emotions, spirit, and body, and the connections between them
- Seek an authentic relationship with me, speaking up when something is not right as well as when something is
- Develop a level of trust with me that will be truly healing for you
- Value my ability to engage in assessing and consulting
- Allow me to be an authentic person, as I encourage the same in you

- Are excited about going deep with your investigation into your health and are open to sharing your insight with me as we co-create a care plan.

Before your first appointment

I work best when I have a "pre-appointment" with you before our scheduled First Office Visit, in the form of an initial paperwork packet that I ask you to fully complete. This is unscheduled and involves me spending time reading and sitting with the information you provide.

The initial packet is how I get to know you and understand how to best approach and attend to your needs. I encourage you to take your time filling out this paperwork; I will learn a huge amount about who you are before we meet face-to-face. This will significantly enhance our work together.

In order to allow time for this process, I will need 48 hours to review your initial packet prior to your First Office Visit. I prefer to spend time reviewing your material when I can take my time, and not yours, to get to know your health concerns. You can scan and email or fax or drop off your packet anytime at least 48 hours before our First Office Visit.

Nature of Ongoing Care

True healing happens slowly, in a sustained manner, accumulating over time. While some improvements will be immediate, others will be revealed over time, as we peel away layers of habits, patterns, or conditions. I generally recommend meeting bi-weekly or monthly for 3-6 months to see how your body responds to this holistic approach.

An important aspect of our relationship is for you to communicate clearly and honestly with me. I'll work to keep us on top of this by communicating my timeline and expectations for change at the end of each of our visits together.

Your Decision

The first step in your commitment to your health is to spend as much time as you need filling out the initial packet. The information I ask of you is what I know leads to effective and lasting healing. If you find the task of filling out the paperwork unpleasant, perhaps working with a different practitioner would serve your needs better.

Take your time, consider deeply, listen to your internal signals…and get back to our office if and when you are interested in working with our office.

Love & Health,

Deika King, ND, MS, MS, CCT

Holistic Breast Specialist™ & Naturopathic Doctor
DEIKA KING

14521 Old Katy Rd. Ste. 240 * Houston, TX 77079 * Tel. 832-422-7271 * Fax 832-747-6146
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NEW BREAST HEALTH CLIENT INFORMATION

Thank you for choosing us as your wellness provider. 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 received in our office 48 hrs. prior to your appointment. NO EXCEPTIONS, otherwise, your visit will have to rescheduled. Your practitioner needs to be able to assess your intake form to determine whether she will be able to assist you in your health journey, or she may require additional documents, testing, labs to assess your health status.**

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: 832-747-6146
Email Address: assistant@deikakingnd.com

Love & Health,

Deika King, ND, MS, MH, CCT
Naturopath, Nutritionist, Herbalist, Clinical Thermographer
Holistic Breast Specialist & Naturopathic Doctor

Welcome

The Owner:

Deika King is a Holistic Practitioner Serving Houston/Katy and surrounding areas. She is a Doctor of Naturopathy, Clinical Nutritionist, Master Herbalist, Clinical Thermographer, Holistic Cancer Coach, Health Coach, Integrative Cancer Educator, and Registered Natural Health Practitioner. She specializes in women's breast health and addresses chronic and acute concerns with the use of nutritional therapy.

At your Nutrition Appointment:

Please allow at least a minimum of 60 minutes for your first appointment and at least 30 to 45 minutes for your follow up visits. 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.

Office Policies

Our office policies are designed to help our clients have a smooth process while working with us. We like to provide structure so that we can provide you with excellent care. Our goal is to make this a great experience for both of us.

Payment

- Our office is a cash-based practice. Clients are responsible for payment in full for services rendered.
- The method of payment for services are cash, credit, debit cards, and checks. A returned check fee of $35 will be assessed in addition to the balance due on "insufficient funds" items.
- **Some HAS programs may cover for these services, but it is your responsibility to verify with your provider prior to your visit.** We are not responsible if they do not cover our services.
- **We require a credit card on file to secure your initial appointment.** All office services are non-refundable.
- Payment will be due at the time of service.
- If there is a balance on your account that we are not able to secure payment for after 30 calendar days, a minimum billing fee of $10 or 2%, whichever is greater, will be added to any unpaid balance.
- Clients with a balance on their account that is over 30 calendar days will need to settle the balance prior to securing a consultation visit. Clients are responsible for all costs, including legal fees, associated with collections on their accounts.

* **All initial appointments require a 30% reservation fee. This fee will be applied to services rendered on the day of your appointment and must be paid at the time the appointment is scheduled.**
* **Appointments cancelled within 48 hours will be refunded their reservation fee.**
* **No show or late cancellations will be charged 50% of the cost of the scheduled appointment.**

Initial _____2

Cancellation/Late Rescheduling

- If for any reason you need to reschedule your appointment, we ask that you please give us a **48 hr. notice** to avoid a late cancellation fee **(50% of your scheduled visit).** This allows us to fill the spot with another client that may need our services. When you schedule your appointment, we are setting aside a time slot specifically to meet your needs.
- You must call our office to cancel. If we do not answer the phone, please leave a message with your name, time, and cancellation notice.
- Please do not email to cancel your appointment, as they may be missed, still making you responsible for late cancellation or rescheduling fee.
- If you are late to your appointment, you will be seen for the remainder of your appointment time to avoid delays to other clients. If you go over your scheduled appointment time, you will be charged for the additional time spent with our naturopath. Please be sure to review our office fee schedule.
- 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 you for the 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.

Communication

- **Email –**
  - Short emails regarding follow-up on care plan or as requested by your provider are acceptable
  - Emails are reviewed and responded to in the order in which they are received. Due to the high volume of emails, it may take up to 1 week for the office to respond, although we will do our best to respond sooner.
  - Emails is not appropriate for new health concerns. If you have a health concerns, or questions, please call the office to make an appointment.
  - Email consultations are not offered.
- **Phone –**
  - Phone consultations are available for established clients only.
  - There is a minimum $50/15 min fee for this service. Must be paid prior to consultation.
- **Texting –**
  - Text are not received or reviewed on the clinic phone.
  - Text to your practitioner will not be accepted as a form of communication regarding either your own or another's healthcare.
- **Off Hours –**
  - If the practitioner is contacted during off hours to address any health related concerns, there will be a $75/15 min fee for this service.

Supplements: The products that we use, whether it's whole food nutrition, herbs, or homeopathy, are powerful and effective. If you choose to work with us, it is important that you follow instructions in order to get the best results. If you add anything to your protocol, it's important that you communicate this with the office, as there may be adverse interactions. Although our products are safe, they can have side effects when mixed with contraindicated herbs, medications, foods, etc. Please COMMUNICATE with us.

The majority of the supplements we provide to our clients are only sold to doctors and healthcare practitioners. These products are typically not sold to the public because they require monitoring. They are powerful and effective, which is why we use them. To ensure that you are on the right path and following protocol, you may be required to schedule additional office visits to monitor your program. If you miss too many visits or have not returned for monitoring in a 90-day period, we will be unable to refill your nutrition order until you have consulted with your practitioner.

Initial ____3

If you need a refill on supplements, herbs, homeopathy, please submit your request at least 7 days prior to running out to prevent a lapse in continuity. **PLEASE MAKE SURE THAT YOU ORDER THE CORRECT SUPPLEMENTS – AS WE DO NOT REFUND ANY SUPPLEMENT ONCE IT LEAVES OUR OFFICE.**

- Orders placed by clients may be picked up in the office. Please check with the front desk for the best time to pick up your order.
- We are happy to ship your supplements. Shipping charges apply
- We will mail you items that were out of stock when requested, pre-paid, FREE of shipping cost.
- We will mail requested refill items after payment is received, including a minimum handling -fee of $5.00 Plus postage.
- Unfortunately, we cannot be responsible for your reception of these items. We cannot re-send or refund if the shipment fails to reach you.

Appointments:

- Your follow-up visits will be made by our front desk prior to you leaving the office. Please bring your calendar so that we can easily schedule your next visit.
- If too many of your scheduled appointments tend to be rescheduled visit after visit, or you have not returned for monitoring after 180-days from last visit, upon your return, we will require a re-exam visit to assess your health status prior to making any recommendations for chronic conditions. You may return any time for acute conditions (cough, cold, etc.)
- We do not accept walk-ins. All appointments must be scheduled ahead of time.
- For Acute visit we highly recommend that you call the office to make sure that we are able to see you at a reasonable time on the same day.
- All lab results may be reviewed and discussed during appointment times, or you may schedule a separate appointment for it.
- **The investment for a lab review whether done in person or via phone is $55/10 min. This is the cost of the practitioner reviewing the information and providing recommendations on how to address the results prior to our consultation visit. This is not part of your regular appointment cost.**
- No refunds are given once the service has been provided or lab test has been purchased.
- Clients who show up to unscheduled appointments to speak with the naturopath will be charged accordingly and will have to wait for the schedule to be clear before being seen. We discourage clients from showing up unannounced without an appointment. You will be billed for time that you speak with the naturopath as it will be considered an appointment.
- We reserve the right to immediately discharge any client from our practice if he/she does not comply with our office policies or does not conduct themselves in a respectful manner.

  If you have not been in the office for a follow up in 6 months, you will need a full-re-evaluation. Lots can change in 6 months. Our best interest is to have a complete evaluation to provide the best care for our clients. We do not want to provide you with inadequate service and for this reason we enforce this policy.

Note: Your practitioner spends additional time on your case for research, notes, communications, therefore the exact time you spend with her during your consultation may vary so that she has time to complete other aspects included in your consultations.

Preparation for your Initial Appointment:

- Please complete our intake form and system survey and **return to our office 48 hours prior** to your appointment.
- Please provide us with a **2-day food log** and bring it with you at the time of your visit. Please do not change your diet during this time.
- **Please refrain from any food, drinks, gum, breath mints for at least 1 hr. prior to your visit, as it may alter some of the terrain testing we will conduct during your visit.**
- Provide a list of all medications and supplements, dosages for each, instructions for taking them, and conditions for which you are taking them.
- **Provide all recent labs, imaging, or reports** that you feel may be necessary in your care process for the last 1yr.
- If you are currently working with other practitioners, please provide the name, specialty, and contact information.
- Please list all known drugs, supplements, foods and environmental **allergies**, your reactions to them, and the severity of these reactions.
- Please download and read our eBook "Wellness Without Limits" found on our website prior to your visit.
- **Wear comfortable clothes to facilitate our non-invasive assessments that will be conducted during your appointment.**
- Make sure that your hair is clean, refrain from using shampoo with fragrances, no resent hair dyes, no resent perms because we may be doing a Tissue Hair Mineral Analysis and that requires a small amount of hair for the evaluation of nutrients and toxins in your system.

Service Options: We require a 30% reservation fee for all Initial Appointments.

Initial Breast Health appointment: 60 minutes - $300
30 minute Follow-up appointment: $100
45 minute Follow-up appointment: $145

Package Options:

6-Week Breast Coaching Package: $600
Includes: Initial Breast Health Assessment (60 min), Program of Care (45 min), 3 (30-min) bi-weekly follow-up visits, 3-BioMat Therapy Sessions, Prevention Education, email correspondence between sessions, nutritional recommendations, 10% off supplements and products, $10 off Thermography Screening.

3-Month Breast Coaching Package: $880
Includes: Initial Breast Health Assessment (60 min), Program of Care (45 min), 6 (30-min) bi-weekly follow-up visits, 6-BioMat Therapy Sessions, Prevention Education, email correspondence between sessions, nutritional recommendations, 10% off supplements and products, $15 off Thermography Screening.

***** We are also able to modify programs to include labs, screening, nutritional supplements, additional assessment and more. Please ask the practitioner******

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:** _____

Initial _____6

Deika King, TND, MH, CCT, PSc.D

Holistic Breast Specialist & Naturopathic Doctor

INFORMED CONSENT STATEMENT

I, _____hereby attest and agree to the following:

1) I fully understand that Deika King is a lay natural health advisor who deals strictly in helping people to improve their general health through better nutrition, noninvasive natural remedies, such as vitamins, mineral, herbs, dietary changes, improved lifestyle, health habits, and positive mental attitude.

2) I fully understand that Deika King is not a licensed physician and cannot diagnose disease, prescribe drugs, or recommend treatments for specific disease conditions.

3) I understand that all evaluations/analysis performed by Deika King or her representatives are designed to evaluate my inherent constitution and temperament for the sole purpose of helping me to improve my general health through nutrition, habits and attitudes. I further understand that said evaluations cannot determine specific disease conditions I may have and do not replace the diagnostic services offered by licensed physicians.

4) I understand that Deika King never claims nor implies that any instruction, advice, counsel, suggestions, recommendations, services, or products she or her representatives provide, whether in person or by mail or by telephone, will cure, treat, prevent or mitigate any disease condition; but are provided solely for the purpose of increasing energy, supporting the natural function of body systems and otherwise improving general health and fitness.

5) I certify that Deika King or her representatives have not suggested that I cease any medical care I may be undertaking. I understand that the decisions I make regarding my health care and the health care of those under my guardianship are my responsibility and certify that I will not hold Deika King or her representatives responsible for the consequences of my decisions.

6) I certify that I am here on this and on any subsequent visit or contact, whether by mail, telephone, or in person, solely on my own behalf and not as an agent or representative of any federal, state, county, or local government or private agency on a mission of investigation.

Initial _____7

7) I understand that I am responsible and accountable for all charges incurred, and any subsequent interest and/or past due charges for unpaid balances, including any charges for collecting on all “past due” bills. Due to Federal Regulations, opened supplements cannot be returned for a refund.

I have read and understand the foregoing and agree to the terms and conditions set therein.

Date: _____ **Referred by:** _____

Client Signature: _____

14251 Old Katy Rd. Ste. 240 Houston, TX 77079
info@deikakingnd.com www.deikakingnd.com

Registration Information

Name:		Date:
How would you prefer to be addressed?		
Address:		
City:	State:	Zip:
Home phone:	Work phone:	
E-mail:		
Date of Birth:	Age:	Gender: ___ Male ___ Female
Occupation:	Hrs. per week:	
Emergency Contact:	Phone:	
Please Check one: __ Married __ Partnership __ Separated __ Divorced __ Widowed __ Single		
Live with: ___ Spouse ___ partner ___ Parents ___ Children ___ Friends ___ Alone ___ Other		
In the event that we are unable to reach you in person by phone, please indicate where it is appropriate for us to leave a message ___ Home machine ___ At Work ___ Never leave messages ___ Email		
How did you hear about our practice?		
What time of the day do you prefer: ___ Mornings ___ Afternoons ___ Evenings ___ No Preference		
Can we add you to our e-Newsletter list to receive current information on the clinic and promotions _____ YES _____ NO		

Holistic Breast Specialist™ & Naturopathic Doctor
DEIKA KING

BREAST HEALTH INTAKE FORM

1. Reason for your visit today:

_____

_____

_____

2. Who referred you to see us? _____
3. Who is your primary care physician? _____
4. Are there any other physicians whom you would like to receive today's visit information?
   ☐ No ☐ Yes
   Physician name and contact information
   Office Number: _____ Fax:_____
   Office Address: _____
   _____

BREAST HISTORY

1. Please indicate any Breast Symptoms you are currently experiencing:
   Mass or Lump: ☐ No ☐ Yes Nipple Discharge: ☐ No ☐ Yes
   Skin Changes: ☐ No ☐ Yes Other: _____
   Breast Pain: ☐ No ☐ Yes Duration of symptoms: _____

2. When was your last mammogram? Date: _____ Facility: _____
   Have you ever had an irregular finding on your mammogram ☐ No ☐ Yes
   Have you had an ultrasound? Date: _____ Facility: _____
   Have you had an MRI? Date: _____ Facility: _____

3. Have you ever had a *previous breast biopsy*? ☐ No ☐ Yes Side: ☐ Left ☐ Right

4. Do you have a history of *prior breast cancer*? ☐ No ☐ Yes Side: ☐ Left ☐ Right
   If yes, year diagnosed: _____
   How was your prior breast cancer treated? ☐ Lumpectomy ☐ Mastectomy
   Did you have lymph node(s) removed? ☐ No ☐ Yes ☐ Sentinel nodes ☐ All lymph nodes
   Did you receive radiation therapy? ☐ No ☐ Yes – If yes, when? _____
   Did you receive chemotherapy? ☐ No ☐ Yes
   Did you receive hormone-blocking/endocrine therapy? ☐ No ☐ Yes

FAMILY HISTORY

1. Are you of Ashkenazi Jewish (Eastern European Jewish) Descent: ☐ No ☐ Yes
2. Do you have a **family history of breast cancer?** ☐ No ☐ Yes ☐ Unknown
3. Do you have a **family history of ovarian cancer**? ☐ No ☐ Yes ☐ Unknown
4. Do you have a **family history of other cancers**? ☐ No ☐ Yes ☐ Unknown

If yes to any of the above, please list family members below.

Relative	Maternal or Paternal?	Cancer Type	Age at cancer diagnosis	Current age, if living	Age at death, if deceased

MEDICAL HISTORY

Please list all significant medical diagnoses/conditions:

SURGERIES/HOSPITALIZATIONS

Please list all operations and hospitalizations and date, if applicable:

MEDICATIONS

Please list all medications/vitamins/supplements you are currently taking:

ALLERGIES

Please list all allergies to medications/foods/substances/ what type of reaction you had:

GYNECOLOGIC HISTORY

1. Age at onset of first period? _____ Last menstrual period? _____
2. Have you experienced menopause? ☐ No ☐ Yes Age at menopause: _____
3. Have you had a hysterectomy? ☐ No ☐ Yes Removal of ovaries? ☐ No ☐ Yes
4. How many pregnancies have you had? _____ How many live births? _____
5. How old were you when your first child was born? _____ Did you Breastfeed? ☐ No ☐ Yes
6. Have you ever had fertility treatments? ☐ No ☐ Yes
7. Have you ever used hormone-based birth control? ☐ No ☐ Yes
   Age started: _____ Age stopped: _____
8. If post-menopausal, have you ever used hormone replacement therapy? ☐ No ☐ Yes
   Age started: _____ Age stopped: _____

PERSONAL/SOCIAL HISTORY

Ethnicity: ☐ Caucasian ☐ African American ☐ Spanish/Hispanic ☐ American Indian/ Aleutian/Eskimo ☐ Asian/Pacific Islander ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Widowed

Do you have children? ☐ No ☐ Yes

If yes, what are their ages? _____

Are you currently employed? ☐ No ☐ Yes

If yes, what is your occupation? _____

Are you currently smoking? ☐ No ☐ Yes

If yes, how much do you smoke? _____packs/day

If you have quit smoking, how long ago did you quit? _____

How many years did you smoke? _____ How much? _____ pack/day

Do you drink alcohol? ☐ No ☐ Yes – Number of drinks per day: _____ per week: _____

Describe your daily activity level: (*Mark only ONE that best describes you now):*

☐ I am fully active and am able to carry on all usual activities without restriction

☐ I am restricted in physically strenuous activity, but can walk and am able to carry on light housework

☐ I can walk and take care of myself, but am unable to carry out work activities

☐ I need help taking care of myself and I spend more than half of the day in bed or a chair

☐ I cannot take care of myself at all and spend most of the day in bed

Holistic Breast Specialist™ & Naturopathic Doctor
DEIKA KING

REVIEW OF SYSTEMS:

Please check off below any significant symptoms you have had in the past 6 months:

Constitutional:
☐ poor appetite
☐ fatigue
☐ weight gain/loss
☐ poor sleep
☐ fever
☐ headache

Psychiatric:
☐ depression
☐ anxiety

Eyes:
☐ blurred vision
☐ double vision
☐ tearing/watery eyes
☐ sensitivity to light

Ears, nose, mouth & throat:
☐ difficulty hearing
☐ ringing in ears
☐ sinus problems
☐ nose bleeds
☐ dry mouth
☐ taste changes
☐ hoarseness
☐ pain with swallowing
☐ difficulty with swallowing

Respiratory:
☐ shortness of breath
☐ cough
☐ coughing up blood
☐ asthma or wheezing

Hematologic/ lymphatic:
☐ enlarged lymph nodes
☐ arm swelling
☐ easy bleeding

Gastrointestinal:
☐ diarrhea
☐ constipation
☐ heartburn or indigestion
☐ nausea
☐ vomiting
☐ blood in stools

Genitourinary:
☐ frequent urination
☐ painful urination
☐ blood in urine
☐ leakage/ incontinence
☐ vaginal dryness

Neurologic:
☐ numbness/tingling
☐ dizziness
☐ memory loss
☐ problems walking/ falls

Cardiovascular:
☐ irregular heart beat
☐ rapid heart rate
☐ chest pain
☐ swelling of feet/ankles
☐ heart murmur

Skin:
☐ itching
☐ easy bruising
☐ rash

Endocrine:
☐ intolerance to heat
☐ excessive thirst
☐ hot flashes
☐ night sweats
☐ chills

Allergic/ Immunologic:
☐ allergies
☐ runny nose
☐ itchy eyes

Musculoskeletal:
☐ bone pain
☐ joint pain
☐ muscle weakness

Patient Name (print) _____Signature_____Date _____Time_____

Representative Signature _____Relationship to Patient_____

Holistic Breast Specialist™
& Naturopathic Doctor
DEIKA KING

Informed Consent

Naturopathy
Naturopaths are trained specialist in a distinct healing art which uses non-invasive natural remedies. Naturopaths assess the whole person, taking into consideration physical, mental, emotional, and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

What to Expect
When you consult with a naturopath for counsel, you will find a person committed to the holistic approach to health. The doctor will gather a medical history, inquire about your diet, discuss any stress you are experiencing, give various non-invasive test designed to evaluate body conditions and advise your concerning your conditions. You will experience techniques which are consistent with traditional naturopath and its philosophy. These will enable your body to correct problems now and prevent them from recurring in the future.

A number of different approaches may be used throughout the course of care. Those modalities may include any of the following:

Botanical Medicine – plant-based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations to assist in recovery from imbalances.
Hydrotherapy – the use of hot and cold-water applications to improve circulation and stimulate the immune system.
Chinese Medicine – the use of body markers such as fingernail and tongue to analyze body functions and the use of herbal medicine alleviate imbalances.
Homeopathy – a form of energetic medicine based on the Law of Similar – that is, the use of tiny does of a substance that cause the same symptom in healthy individual, but when matched to an unhealthy individual, stimulates the body's ability to over come those symptoms and health itself.
Nutritional Medicine – refers to the use of specific individualized dietary and supplemental recommendations to address deficiencies and promote health.
Lifestyle Counseling – Involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.
Thermotherapy – with the use of BioMat we are able to expose body tissue to high temperature which can damage and kill cancer cells with minimal injury to normal tissue. This form of therapy is known to reverse degenerative disease cycles, active mitochondria and speeds cellular renewal.
Thermography Screening – is the use of Digital Infrared Imaging as a health risk assessment to evaluate and detect subtle physiological change in the body.
Biofeedback – is a non-invasive process of discovering any physiological function primarily with instruments or techniques that provide information on the activity of those systems. In our office we use Muscle Response Testing.
And others.

Potential Risk

Even the gentle therapies have their complications in certain physiological conditions such as pregnancy, lactation, in clients who are very young/very old, or in people who take multiple medications. Some therapies must be used with caution in certain individual wo suffer with diabetes, lung, heart, liver or kidney problems. It is very important that you are completely forthright in informing your ND of any disease process currently going on in your body, if you are on any prescription medications, over the counter, or illegal drugs. If you are pregnant or suspect you are pregnant, or you are breast-feeding please advise your practitioner immediately.

There are some slight health risks to naturopathic various therapies. These include but are not limited to:

- Aggravation to pre-existing conditions and symptoms
- Allergic reaction to supplements or botanical recommendations
- Going through the healing crisis
- Reactions to detoxification which may include headaches, nausea, flu like symptoms, etc.
- Other unforeseen health risk.

Consent to Care:

I, _____ hereby attest and agree to the following:

1) I fully understand that Deika King is a lay natural health advisor who deals strictly in helping people to improve their general health through better nutrition, noninvasive natural remedies, such as vitamins, mineral, herbs, dietary changes, improved lifestyle, health habits, and positive mental attitude.

2) I fully understand that Deika King is not a licensed physician and cannot diagnose disease, prescribe drugs, or recommend treatments for specific disease conditions.

3) I understand that all evaluations/analysis performed by Deika King or her representatives are designed to evaluate my inherent constitution and temperament for the sole purpose of helping me to improve my general health through nutrition, habits and attitudes. I further understand that said evaluations cannot determine specific disease conditions I may have and do not replace the diagnostic services offered by licensed physicians.

4) I understand that Deika King never claims nor implies that any instruction, advice, counsel, suggestions, recommendations, services or products she or her representatives provide, whether in person or by mail or by telephone, will cure, treat, prevent or mitigate any disease condition; but are provided solely for the purpose of increasing energy, supporting the natural function of body systems and otherwise improving general health and fitness.

5) I certify that Deika King, or her representatives have not suggested that I cease any medical care I may be undertaking. I understand that the decisions I make regarding my health care and the health care of those under my guardianship are my responsibility and certify that I will not hold Deika King or her representatives responsible for the consequences of my decisions.

6) I certify that I am here on this and on any subsequent visit or contact, whether by mail, telephone, or in person, solely on my own behalf and not as an agent or representative of any federal, state, county, or local government or private agency on a mission of investigation.

7) I understand that I am responsible and accountable for all charges incurred, and any subsequent interest and/or past due charges for unpaid balances, including and charges for collecting on all “past due” bills. Due to Federal Regulations, opened supplements cannot be returned for a refund.

I have read and understand the foregoing and agree to the terms and conditions set therein.

Date: _____ Referred by: _____

Client Signature: _____

Systems Survey Form | Restricted to Professional Use

Holistic Breast Specialist™ & Naturopathic Doctor
DEIKA KING

NAME: AGE: HEALTH CARE PROFESSIONAL: DATE:

INSTRUCTIONS: Circle the number that applies to you. **If a symptom does not apply, don't circle anything** for that symptom.

Circle the corresponding number.	
1	MILD symptom (occurs rarely)
2	MODERATE symptom (occurs several times a month)
3	SEVERE symptom (occurs almost constantly)

GROUP 1

1. 1 2 3 Acid foods upset
2. 1 2 3 Get chilled often
3. 1 2 3 "Lump" in throat
4. 1 2 3 Dry mouth, eyes, nose
5. 1 2 3 Pulse speeds after meal
6. 1 2 3 Keyed up, fail to calm
7. 1 2 3 Gag occasionally
8. 1 2 3 Unable to relax, startle easily
9. 1 2 3 Extremities cold, clammy
10. 1 2 3 Strong light irritates
11. 1 2 3 Occasionally weak urine flow
12. 1 2 3 Heart pounds after retiring
13. 1 2 3 "Nervous" stomach
14. 1 2 3 Appetite reduced occasionally
15. 1 2 3 Cold sweats often
16. 1 2 3 Get heated easily
17. 1 2 3 Nerve discomfort
18. 1 2 3 Staring, blink little
19. 1 2 3 Sour stomach frequent

___ ___ ___ TOTAL
1 2 3

GROUP 2

20. 1 2 3 Joint stiffness after arising
21. 1 2 3 Muscle, leg, toe cramps at night
22. 1 2 3 "Butterfly" stomach, cramps
23. 1 2 3 Eyes or nose watery
24. 1 2 3 Eyes blink often
25. 1 2 3 Eyelids swollen, puffy
26. 1 2 3 Indigestion soon after meals
27. 1 2 3 Always seem hungry, feel "lightheaded" often
28. 1 2 3 Digestion rapid
29. 1 2 3 Vomit occasionally
30. 1 2 3 Hoarseness frequent
31. 1 2 3 Uneven breathing
32. 1 2 3 Pulse slow
33. 1 2 3 Gagging reflex slow
34. 1 2 3 Difficulty swallowing
35. 1 2 3 Temporary constipation or diarrhea
36. 1 2 3 "Slow starter"
37. 1 2 3 Get "chilled"
38. 1 2 3 Perspire easily
39. 1 2 3 Sensitive to cold
40. 1 2 3 Upper respiratory challenges

___ ___ ___ TOTAL
1 2 3

GROUP 3

41. 1 2 3 Eat when nervous
42. 1 2 3 Excessive appetite
43. 1 2 3 Hungry between meals
44. 1 2 3 Irritable before meals
45. 1 2 3 Get "shaky" if hungry
46. 1 2 3 Fatigue, eating relieves
47. 1 2 3 "Lightheaded" if meals delayed
48. 1 2 3 Heart palpitates if meals missed or delayed
49. 1 2 3 Fatigue in afternoon
50. 1 2 3 Overeating sweets upsets
51. 1 2 3 Awaken after few hours sleep, hard to get back to sleep
52. 1 2 3 Crave candy or coffee in afternoon
53. 1 2 3 Moods of "blues" or melancholy
54. 1 2 3 Craving for sweets or snacks

___ ___ ___ TOTAL
1 2 3

GROUP 4

55. 1 2 3 Hands and feet go to sleep easily, numbness
56. 1 2 3 Sigh frequently, "air hunger"
57. 1 2 3 Aware of "breathing heavily"
58. 1 2 3 High-altitude discomfort
59. 1 2 3 Open windows in closed room
60. 1 2 3 Immune system challenges
61. 1 2 3 Afternoon "yawner"
62. 1 2 3 Get "drowsy" often
63. 1 2 3 Swollen ankles worse at night
64. 1 2 3 Muscle cramps, worse during exercise; get "charley horse"
65. 1 2 3 Difficulty catching breath, especially during exercise
66. 1 2 3 Tightness or pressure in chest, worse on exertion
67. 1 2 3 Skin discolors easily after impact
68. 1 2 3 Tendency to anemia
69. 1 2 3 Noises in head or "ringing in ears"
70. 1 2 3 Fatigue upon exertion

___ ___ ___ TOTAL
1 2 3

GROUP 5

71. 1 2 3 Dizziness
72. 1 2 3 Dry skin
73. 1 2 3 Burning feet
74. 1 2 3 Blurred vision
75. 1 2 3 Itching skin and feet
76. 1 2 3 Hair loss
77. 1 2 3 Occasional skin rashes
78. 1 2 3 Bitter, metallic taste in mouth in morning
79. 1 2 3 Occasional constipation
80. 1 2 3 Worrier, feels insecure
81. 1 2 3 Nausea occasionally after eating
82. 1 2 3 Greasy foods upset
83. 1 2 3 Stools light-colored
84. 1 2 3 Skin peels on foot soles
85. 1 2 3 Discomfort between shoulder blades
86. 1 2 3 Occasional laxative use
87. 1 2 3 Stools alternate from soft to watery
88. 1 2 3 Sneezing attacks
89. 1 2 3 Dreaming, nightmare-type bad dreams
90. 1 2 3 Bad breath (halitosis)
91. 1 2 3 Milk products cause upset
92. 1 2 3 Sensitive to hot weather
93. 1 2 3 Burning or itching anus
94. 1 2 3 Crave sweets

___ ___ ___ TOTAL
1 2 3

GROUP 6

95. 1 2 3 Loss of taste for meat
96. 1 2 3 Lower bowel gas several hours after eating
97. 1 2 3 Burning stomach sensations, eating relieves
98. 1 2 3 Coated tongue
99. 1 2 3 Pass large amounts of foul-smelling gas
100. 1 2 3 Indigestion ½-1 hour after eating; may be up to 3-4 hours after
101. 1 2 3 Watery or loose stool
102. 1 2 3 Gas shortly after eating
103. 1 2 3 Stomach "bloating"

___ ___ ___ TOTAL
1 2 3

GROUP 7A

104. 1 2 3 Difficulty sleeping
105. 1 2 3 On edge
106. 1 2 3 Can't gain weight
107. 1 2 3 Intolerance to heat
108. 1 2 3 Highly emotional
109. 1 2 3 Flush easily
110. 1 2 3 Night sweats
111. 1 2 3 Thin, moist skin
112. 1 2 3 Inward trembling
113. 1 2 3 Heart races
114. 1 2 3 Increased appetite without weight gain
115. 1 2 3 Pulse fast at rest
116. 1 2 3 Eyelids and face twitch
117. 1 2 3 Irritable and restless
118. 1 2 3 Can't work under pressure

___ ___ ___ TOTAL
1 2 3

GROUP 7B

119.	1	2	3	Increase in weight
120.	1	2	3	Decrease in appetite
121.	1	2	3	Fatigue easily
122.	1	2	3	Ringing in ears
123.	1	2	3	Sleepy during day
124.	1	2	3	Sensitive to cold
125.	1	2	3	Dry or scaly skin
126.	1	2	3	Temporary constipation
127.	1	2	3	Mental sluggishness
128.	1	2	3	Hair coarse, falls out
129.	1	2	3	Tension in head upon arising wears off during day
130.	1	2	3	Slow pulse below 65
131.	1	2	3	Changing urinary function
132.	1	2	3	Sounds appear diminished
133.	1	2	3	Reduced initiative

____ ____ ____ TOTAL
1 2 3

GROUP 7C

134.	1	2	3	Failing memory with age
135.	1	2	3	Increased sex drive
136.	1	2	3	Episodes of tension in head
137.	1	2	3	Decreased sugar tolerance

____ ____ ____ TOTAL
1 2 3

GROUP 7D

138.	1	2	3	Abnormal thirst
139.	1	2	3	Bloating of abdomen
140.	1	2	3	Weight gain around hips or waist
141.	1	2	3	Sex drive reduced or lacking
142.	1	2	3	Tendency for stomach issues
143.	1	2	3	Immune system challenges
144.	1	2	3	Menstrual disorders

____ ____ ____ TOTAL
1 2 3

GROUP 7E

145.	1	2	3	Dizziness
146.	1	2	3	Headaches
147.	1	2	3	Hot flashes
148.	1	2	3	Hair growth on face or body (female)
149.	1	2	3	Sugar in urine (not diabetes)
150.	1	2	3	Masculine tendencies (female)

____ ____ ____ TOTAL
1 2 3

GROUP 7F

151.	1	2	3	Weakness, dizziness
152.	1	2	3	Tired throughout day
153.	1	2	3	Nails weak, ridged
154.	1	2	3	Sensitive skin
155.	1	2	3	Stiff joints
156.	1	2	3	Perspiration increase
157.	1	2	3	Bowel discomfort
158.	1	2	3	Poor circulation
159.	1	2	3	Swollen ankles
160.	1	2	3	Crave salt
161.	1	2	3	Areas of skin darkening
162.	1	2	3	Upper respiratory sensitivity
163.	1	2	3	Tiredness
164.	1	2	3	Breathing challenges

____ ____ ____ TOTAL
1 2 3

GROUP 8

165.	1	2	3	Muscle weakness
166.	1	2	3	Lack of stamina
167.	1	2	3	Drowsiness after eating
168.	1	2	3	Muscular soreness
169.	1	2	3	Heart races
170.	1	2	3	Hyperirritable
171.	1	2	3	Feeling of a band around head
172.	1	2	3	Melancholia (feeling of sadness)
173.	1	2	3	Swelling of ankles
174.	1	2	3	Change in urinary function
175.	1	2	3	Tendency to consume sweets/carbohydrates
176.	1	2	3	Muscle spasms
177.	1	2	3	Blurred vision
178.	1	2	3	Involuntary muscle action
179.	1	2	3	Numbness
180.	1	2	3	Night sweats
181.	1	2	3	Rapid digestion
182.	1	2	3	Sensitivity to noise
183.	1	2	3	Redness of palms of hands and bottom of feet
184.	1	2	3	Visible veins on chest and abdomen
185.	1	2	3	Hemorrhoids
186.	1	2	3	Apprehension (feeling that something bad is going to happen)
187.	1	2	3	Nervousness causing loss of appetite
188.	1	2	3	Nervousness with indigestion
189.	1	2	3	Gastritis
190.	1	2	3	Forgetfulness
191.	1	2	3	Thinning hair

____ ____ ____ TOTAL
1 2 3

FEMALE ONLY

192.	1	2	3	Very easily fatigued
193.	1	2	3	Premenstrual tension
194.	1	2	3	Menses more painful than usual
195.	1	2	3	Depressed feelings before menstruation
196.	1	2	3	Painful breasts during menses
197.	1	2	3	Menstruate too frequently
198.	1	2	3	Hysterectomy/ovaries removed
199.	1	2	3	Menopausal hot flashes
200.	1	2	3	Menses scanty or missed
201.	1	2	3	Acne, worse at menses

____ ____ ____ TOTAL
1 2 3

MALE ONLY

202.	1	2	3	Less involved in exercise/social activities
203.	1	2	3	Difficult to postpone urination
204.	1	2	3	Weak urinary stream
205.	1	2	3	Feeling of "blues" or melancholy
206.	1	2	3	Feeling of incomplete bowel evacuation
207.	1	2	3	Lack of energy
208.	1	2	3	Muscles in arms and legs seem softer/smaller
209.	1	2	3	Tire too easily
210.	1	2	3	Avoid activity
211.	1	2	3	Leg nervousness at night
212.	1	2	3	Diminished sex drive

____ ____ ____ TOTAL
1 2 3

IMPORTANT | Please list below the five main physical complaints you have in order of their importance.

1. _____
2. _____
3. _____
4. _____
5. _____

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Digestion

_____ Hydrochloric Acid Point

_____ Enzyme Point

_____ Murphy's Sign

Large Intestine (Palpate)

_____ Ascending

_____ Transverse

_____ Descending

Adrenals

Pass/Fail Pupil Dilation Exam

Postural Hypotension

_____ Supine

_____ Standing

Pass/Fail Zinc Taste Test

Pass/Fail Cuff Test

_____ Cuff Pressure

_____ pH of Saliva

_____ Pulse

BARNES THYROID TEST

The test is conducted by the patient in the morning before leaving bed, with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test such as getting up for any reason, shaking down the thermometer, etc. It is important that the test, be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES (any two days during the month)
FEMALES HAVING MENSTRUAL CYCLES (the second and third days of flow or any five days in a row)
MALES (any two days during the month)

Day 1 _____ Day 2 _____ Day 3 _____ Day 4 _____ Day 5 _____

RESTRICTIONS ON USE

The systems survey is to be used only by trained health care professionals. If you are a patient, you should not use the systems survey. If you are not a trained health care practitioner, you should not use the systems survey. Health care practitioners should only use the systems survey to provide services that are within the scope of their license or professional training. The systems survey is intended to be used as a helpful tool for health care practitioners in collecting information concerning the health and wellness of patients.