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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



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www.DeikaKingND.com

NEW NUTRITION 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

Initial _____1

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.**

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.

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 Nutritional appointment: 60 minutes - \$300

30 minute Follow-up appointment: \$100

45 minute Follow-up appointment: \$145

Package Options:

Wholesome Nutrition Bundle: \$400

Includes: 4 (30-min) follow-up visits, 1-Ionic Foot Detox Bath, email correspondence between sessions, nutrition education and counseling, nutritional recommendations, 10% off supplements and products, \$50 off Re-exam visit (reg. \$150)

NutriVitality Bundle: \$765

Includes: 8 (30-min) follow-up visits, 2-Ionic Foot Detox Bath, email correspondence, between sessions, nutrition education and counseling, nutritional recommendations, 10% off supplements and products, \$50 off Re-exam visit (reg. \$150)

Nourish & Flourish Bundle: \$1140

Includes: 12 (30-min) follow-up visits, 3-Ionic Foot Detox Bath, email correspondence, between sessions, nutrition education and counseling, nutritional recommendations, 10% off supplements and products, \$50 off Re-exam visit (reg. \$150)

***** 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:** _____

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.

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: _____

Confidential Intake Form

Section 1: Registration Information

Name:		Date:
How would you prefer to be addressed?		
Address:		
City:	Province:	Postal Code:
Home phone:	Work phone:	
E-mail:		
Date of Birth:	Age:	Gender: <input type="checkbox"/> Male; <input type="checkbox"/> Female
Occupation:	Hrs per Week:	
Emergency Contact:	Phone:	
Please Check One: <input type="checkbox"/> Married/ <input type="checkbox"/> Partnership/ <input type="checkbox"/> Separated/ <input type="checkbox"/> Divorced/ <input type="checkbox"/> Widowed/ <input type="checkbox"/> Single		
Live with: <input type="checkbox"/> Spouse/ <input type="checkbox"/> Partner/ <input type="checkbox"/> Parents/ <input type="checkbox"/> Children/ <input type="checkbox"/> Friends/ <input type="checkbox"/> Alone/ <input type="checkbox"/> 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 messages: <input type="checkbox"/> Home message machine/ <input type="checkbox"/> At work/ <input type="checkbox"/> Never leave messages / <input type="checkbox"/> E-mail		
How did you hear about our practice?		
What time of day do you prefer: <input type="checkbox"/> Mornings / <input type="checkbox"/> Afternoon / <input type="checkbox"/> Evenings / <input type="checkbox"/> No Preference		
Can we add you to our e-Newsletter list to receive current information on the clinic & promotions <input type="checkbox"/> Yes/ <input type="checkbox"/> No		

Section 2: Health Overview

What are your health concerns, in order of importance to you?:

- 1) _____ 2) _____
 3) _____ 4) _____
 5) _____ 6) _____

Is this your first visit to a Naturopathic Doctor? Yes/ No If No, please specify: _____

Religious affiliations and beliefs relevant to health care and Program of Care: _____

Other Health Care Providers

Name of current Family Physician: _____

Family Physician's contact (Phone and Fax): _____

When was your last visit to your Family Doctor?: _____

When was your last physical exam?: _____

Are you seeing a medical specialist?: Yes/ No If Yes, for what reason?: _____

If yes, Name of medical specialist: _____

If yes, medical specialist's contact information: _____

Other health care providers: _____

Other health care providers contact information: _____

Current Medications & Supplements

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics etc.). If possible, also list dosage information and how long you have been taking the medication as well as the brand.

Medication/ Supplement	Dosage/Duration

Medication/ Supplement	Dosage/Duration

Allergies

Please list all known allergies (medications, environmental, chemical, food etc.):

Section 3: Health History

Current Health Status

How would you describe your general state of health? Excellent/ Good/ Fair/ Poor
 Height_____Weight_____Weight 1 year ago_____Maximum weight_____When?_____
 Have you gained/ lost any weight lately? If so, please state how much:_____

Please list a typical dietary intake for you:

- Breakfast:
- Lunch:
- Dinner:
- Snack:

Food groups avoided?:_____Why?:_____

Food cravings?:_____

When during the day is your energy and alertness best?_____Worst?_____

Please rate the following on a scale of 1 to 10 (10 being the **HIGHEST STRESSOR**) (circle for each):

Work/School Stress	1	2	3	4	5	6	7	8	9	10
Home Stress	1	2	3	4	5	6	7	8	9	10
Emotional Stress	1	2	3	4	5	6	7	8	9	10
Relationship Stress	1	2	3	4	5	6	7	8	9	10
Everyday Stress	1	2	3	4	5	6	7	8	9	10
Energy levels	1	2	3	4	5	6	7	8	9	10
Quality of Sleep	1	2	3	4	5	6	7	8	9	10
Memory in general	1	2	3	4	5	6	7	8	9	10

How much time do you spend outdoors on a daily basis? _____
 Regular exercise: Yes No Type: _____ Duration: _____ Frequency: _____
 Primary interests and hobbies: _____

Average hours of sleep per night? _____ Do you wake feeling rested? Yes/ No/ Sometimes
 Any trouble: falling asleep?/ staying asleep?/ wake often?/ wake early?/ difficulty waking?

Do you have regular bowel movements? Yes/ No Are they painful to pass? Yes/ No
 Do you experience Gas Yes/ No - Bloating Yes/ No - Indigestion Yes/ No -
 Acid reflux Yes/ No
 What is the color of your stool? _____ Is it well formed? Yes/ No
 Is there ever blood in your stool? Yes/ No Mucous? Yes/ No Undigested foods? Yes/ No

Menses: How many days is the cycle (i.e. 28 days) _____ Is the menstrual cycle regular? Yes/ No
 PMS symptoms? Yes/ No - Bloating Yes/ No - Headaches Yes/ No - Cramps Yes/ No

Do you use any of the following?:

Substance	Form/ Type	Amount per day/ week/ or month (please specify)
Alcohol		
Tobacco (cigarettes)		
Recreational drugs		
Caffeine (Tea/ Coffee etc.)		
Carbonated beverages		
Laxatives		
Diet pills/ Appetite suppressants		
Antacids		
Pain relievers		
Birth Control Pill		
Fast food		
Water		

Hospitalizations, Surgeries, Imaging

Do you get regular screening tests done by another doctor (Pap, Blood tests, DRE etc?) No Yes
 Please list any hospitalizations, surgeries, X-rays, and other imaging scans that you have had:

_____ Year: _____ Year: _____
 _____ Year: _____ Year: _____
 _____ Year: _____ Year: _____
 _____ Year: _____ Year: _____

Family Health History

Please check each relevant condition for blood relatives only: I do not know my family medical history

<input type="checkbox"/> Allergies	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Asthma	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Cancer (specify type)	
<input type="checkbox"/> Chronic bronchitis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Depression	<input type="checkbox"/> Drug abuse
<input type="checkbox"/> Eating disorders	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Heart disease	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Mental illness
<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Parasites/worms
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Skin diseases	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Other:		

Please list ages, health problems and if deceased, cause of death:

Family member	Living (age?)	Died (age?)	Condition(s)/ Cause of Death
Mother			
Father			
Brother(s)			
Sister(s)			
Child(ren)			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/ Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/ Uncles			

Section 4: Goals for Health

What expectations do you have for your visit with me today?

What long term goals and expectations do you have from working with me?

What expectations do you have of me personally as your Naturopathic Doctor?

Is there anything else you would like me to know at this time?

Please list any limitations to care that I must be aware of: (ie: work restrictions (hours/ shift work), language, physical etc....)

Patient/ Guardian Signature:_____

Date:_____

Thank you for taking the time to complete this extensive intake form.

Please return this form to the office of Deika King, ND, MS, MH, CCT **prior to your first visit** so that she can evaluate and assess the given information and provide you with well researched program of care options and recommendations.

Systems Survey Form | Restricted to Professional Use



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 1/2-1 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

____ 1 ____ 2 ____ 3 **TOTAL**

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

____ 1 ____ 2 ____ 3 **TOTAL**

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

____ 1 ____ 2 ____ 3 **TOTAL**

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)

____ 1 ____ 2 ____ 3 **TOTAL**

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

____ 1 ____ 2 ____ 3 **TOTAL**

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

____ 1 ____ 2 ____ 3 **TOTAL**

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

____ 1 ____ 2 ____ 3 **TOTAL**

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

____ 1 ____ 2 ____ 3 **TOTAL**

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	Large Intestine (Palpate)	Adrenals	Pass/Fail Zinc Taste Test
_____ Hydrochloric	_____ Ascending	Pass/Fail Pupil Dilation Exam	Pass/Fail Cuff Test
_____ Acid Point	_____ Transverse	Postural Hypotension	_____ Cuff Pressure
_____ Enzyme Point	_____ Descending	_____ Supine	_____ pH of Saliva
_____ Murphy's Sign		_____ Standing	_____ 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.



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 doses of a substance that cause the same symptom in healthy individual, but when matched to an unhealthy individual, stimulates the body's ability to overcome those symptoms and heal 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, activate 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 who 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: _____