

Women's Patient Health Questionnaire

Do you have or have you experienced the following in the past six months:

- | | | |
|---|--|--|
| <input type="checkbox"/> Autoimmune diseases (Z13.228) | <input type="checkbox"/> Lung disease (R06.02) | <input type="checkbox"/> High blood pressure or medication use (I11.9,I10) |
| <input type="checkbox"/> Susceptibility to infections (Z00.00) | <input type="checkbox"/> Other specified abnormal findings of blood chemistry (R79.89) | <input type="checkbox"/> Abnormal cholesterol or medication use (E78.5) |
| <input type="checkbox"/> Slow wound healing (T81.30) | <input type="checkbox"/> Snoring while sleeping (R06.83, G47.33) | <input type="checkbox"/> Heart disease (I70.90) |
| <input type="checkbox"/> Decreased stamina (R53.1) | <input type="checkbox"/> Insomnia (G47.00) | <input type="checkbox"/> History of stroke / TIA (G45.9, I63.9) |
| <input type="checkbox"/> Tobacco use (F17.210) | <input type="checkbox"/> Osteoporosis / brittle bones (M81.0) | <input type="checkbox"/> Family history of heart disease (Z82.49) |
| <input type="checkbox"/> Daily alcohol consumption (F10.99) | <input type="checkbox"/> Osteoarthritis (M15.9) | <input type="checkbox"/> Shortness of breath (R06.02) |
| <input type="checkbox"/> Prescription medication use (Z79.899) | <input type="checkbox"/> Memory loss (R41.3) | <input type="checkbox"/> Family history of diabetes (Z83.3) |
| <input type="checkbox"/> Constipation (<1 movement/day) (K59.00) | <input type="checkbox"/> Diabetes / pre-diabetes (E11.8, R73.01) | <input type="checkbox"/> Large waist circumference (high risk >40') (E88.81) |
| <input type="checkbox"/> Gas / bloating (R14.0, R14.3) | <input type="checkbox"/> Abnormal blood sugar (R73.09) | <input type="checkbox"/> Recreational drug use (F12.99) |
| <input type="checkbox"/> Indigestion / Heartburn (R12) | <input type="checkbox"/> Decreased sweating (E88.9) | <input type="checkbox"/> Asthma / Wheeze (J45.909, R06.2) |
| <input type="checkbox"/> Food cravings (R63.2) | <input type="checkbox"/> Recent weight gain (R63.5) | <input type="checkbox"/> Chronic cough (R05) |
| <input type="checkbox"/> Irritable bowels (K58.9,K52.29) | <input type="checkbox"/> Pigmented skinfolds (E88.81) | <input type="checkbox"/> Chronic pain (G89.29) |
| <input type="checkbox"/> Iron deficiency/Anemia (D50.8, D50.9) | <input type="checkbox"/> Skin tags (fleshy profusion) (E88.81) | <input type="checkbox"/> Excessive Thirst (R63.1) |
| <input type="checkbox"/> Nutritional Anemia (D53.9) | <input type="checkbox"/> Gout (E79.0) | <input type="checkbox"/> Dry mouth (R68.2) |
| <input type="checkbox"/> Kidney disease (N18.9) | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sinus congestion (R09.81) |
| <input type="checkbox"/> Fatty liver disease (K76.9) | <input type="checkbox"/> Varicose veins (I83.90) | <input type="checkbox"/> Dark circles / bags under eyes (R53.83) |
| <input type="checkbox"/> Gall bladder attacks (80.21) | <input type="checkbox"/> History of blood clots (I80.299) | <input type="checkbox"/> Hypothyroid (E03.9) |
| <input type="checkbox"/> Sexual thoughts (<2-3 times a month) (F52.9) | <input type="checkbox"/> Tender breasts (N64.9) | <input type="checkbox"/> Cold hands and feet (E88.9) |
| <input type="checkbox"/> Low libido / sexual function (R68.82) | <input type="checkbox"/> Cystic ovaries (N83.20) | <input type="checkbox"/> Excess sweating (R61) |
| <input type="checkbox"/> Hormonal disorder, unspecified (E34.9) | <input type="checkbox"/> Uterine fibroids (N94.6) | <input type="checkbox"/> Heart palpitations (R00.2) |
| <input type="checkbox"/> Polycystic ovarian syndrome (E28.2) | <input type="checkbox"/> Urinary incontinence (N39.41) | <input type="checkbox"/> Using hormone medication (Z79.3) |
| <input type="checkbox"/> Menopausal Symptoms (N95.1) | <input type="checkbox"/> Vaginal dryness / painful sex (N94.1) | <input type="checkbox"/> Use of birth control pills (Z79.3) |
| <input type="checkbox"/> Sadness (R45.2) | <input type="checkbox"/> Fertility problems (N97.9) | <input type="checkbox"/> Increased back hair (L68.0) |
| <input type="checkbox"/> Low energy (R53.82) | <input type="checkbox"/> Decreased urine flow (R39.19) | <input type="checkbox"/> Excess hair loss (L64.9) |
| <input type="checkbox"/> Fatigue (R53.82) | <input type="checkbox"/> Increased urinary urge (R39.19) | <input type="checkbox"/> Excess body odor (R46.0) |
| <input type="checkbox"/> Inability to walk more than 1 km (R53.81) | <input type="checkbox"/> Decreased muscle mass (R53.1) | <input type="checkbox"/> Swelling of feet / ankles (R60.9) |
| <input type="checkbox"/> Decreased flexibility-can't bend or kneel (M25.60) | <input type="checkbox"/> Feeling burn out (R53.83) | <input type="checkbox"/> Low blood pressure (R03.1) |
| <input type="checkbox"/> Not able to engage in vigorous activity (R53.1) | <input type="checkbox"/> Inability to lose weight (E66.3) | <input type="checkbox"/> Using antidepressant medications (F32.9, F13.29) |
| <input type="checkbox"/> Low motivation levels (R45.84) | <input type="checkbox"/> Fatigue / drowsiness (R53.83, R40.0) | <input type="checkbox"/> Dry / rough skin (R23.4) |
| <input type="checkbox"/> Decreased mental sharpness (R41.840) | <input type="checkbox"/> Water retention (R60.9) | <input type="checkbox"/> Thin skin / poor elasticity (R23.9) |
| <input type="checkbox"/> Hot flashes (N95.9) | <input type="checkbox"/> Migraines (G43.0) | <input type="checkbox"/> Food allergies (T78.40) |
| <input type="checkbox"/> Heavy menses (N93.8) | <input type="checkbox"/> Fibromyalgia (M79.7) | <input type="checkbox"/> Hive / itchy skin (L50.9) |
| <input type="checkbox"/> Menstrual irregularities (N92.6) | <input type="checkbox"/> Nontoxic goiter (E04.9) | <input type="checkbox"/> Skin breakouts / flares (R21) |
| <input type="checkbox"/> Fibrocystic breasts (N64.9) | <input type="checkbox"/> Disorder of Thyroid (E07.9) | <input type="checkbox"/> Dark skin discolorations around neck (E88.1) |
| <input type="checkbox"/> Excessive / chronic stress (R45.7) | <input type="checkbox"/> Leg pain (M79.609) | <input type="checkbox"/> Increased wrinkles (R23.9) |
| <input type="checkbox"/> Mood fluctuations (R45.86) | <input type="checkbox"/> Back pain (M54.89) | <input type="checkbox"/> Acne / oily skin (L70.9) |
| <input type="checkbox"/> Irritable (R45.1) | <input type="checkbox"/> Joint pain (M25.50) | <input type="checkbox"/> Immune or hormone skin cream use (Z79.3) |
| <input type="checkbox"/> Anger outbursts (R45.4) | <input type="checkbox"/> Numbness/tingling (R20.2) | <input type="checkbox"/> Sugar cravings (E63.1) |
| <input type="checkbox"/> Depressed (F32.9) | <input type="checkbox"/> Using steroid medication (E24.9) | <input type="checkbox"/> Recent / pending surgery/procedure (Z01.818) |
| <input type="checkbox"/> Anxiety (R45.82, F41.1) | <input type="checkbox"/> Purple / pink stretch marks (E24.9) | <input type="checkbox"/> Heart failure, unspecified (I50.9) |
| <input type="checkbox"/> Foggy thinking / disorientation (R41.840) | <input type="checkbox"/> Excess belly hip fat (E28.0, E66.3, E66.0) | <input type="checkbox"/> Intestinal malabsorption, unspecified (K90.90) |
| <input type="checkbox"/> Need caffeine to get going (R53.83) | <input type="checkbox"/> Abnormal Weight Loss (R63.4) | <input type="checkbox"/> Seasonal Allergies/Rhinitis (J30.9, J30.2) |
| <input type="checkbox"/> Morning fatigue (G47.9) | <input type="checkbox"/> Abdominal Pain (R10.9) | |
| <input type="checkbox"/> Feel run down (R40.0) | <input type="checkbox"/> Headaches (G44.229) | |
| <input type="checkbox"/> Feel wired before bed (G47.9) | <input type="checkbox"/> Using pain / anxiety medication (F11.99) | |
| <input type="checkbox"/> Low Vit D (E55.9) | <input type="checkbox"/> Eczema (L30.9) | |
| <input type="checkbox"/> Thinning hair (L64.9) | <input type="checkbox"/> Psoriasis (L40.9) | |
| | <input type="checkbox"/> Sleep disturbance (G47.00) | |

Talk to your practitioner about performing advance blood testing to:

(1) Find the root cause of your symptoms & concerns (2) Uncover hidden risks (3) Know your baseline

Name: _____ Signature: _____ Date: _____

Patient Name: _____

Date: _____

DIGESTIVE SYSTEM

- Gas Bloating
- Constipation
- Loose stool Irritable Bowl
- Crohn's Celiac
- Stomach Pain
- Nausea Burping
- Acid Reflux Heartburn
- Parasites
- Ulcers
- Oily or smelly stools
- Hemorrhoids Bleeding
- Bowel Movements ___/ Day

VASCULAR SYSTEM

- Heart Pain Tremors
- Dizziness
- High Blood Pressure
- Low Blood Pressure
- High Cholesterol
- Bruise Easily
- Heart Pounds
- Shaky

ENDOCRINE SYSTEM

- Fatigue Exhaustion
- Sleep Does Not Refresh
- Brittle Fingernails
- Hair Falling Out
- Sleep Difficulties
- Low Sex Drive
- Weight Gain
- Crave Salt Sugar
- Feel Cold Feel Hot
- Poor Memory

THYROID CONDITION

- Hyper Hypo
- Orange/Yellow Palms, Soles
- Quivering Tongue

DIABETIC

- Type 1 Type 2
- Pre-diabetic
- Sweaty Palms, feet

NEUROLOGICAL

- Depression
- Low Self Esteem
- Mood Swings
- Poor Sleep
- Anxiety / Panic Attacks

RESPIRATORY SYSTEM

- Shortness of Breath
- Asthma
- Colds
- Frequent Yawning
- Clear Throat Frequently
- Sore Throat
- Phlegm, Nasal Drip
- Itchy Ears

IMMUNE SYSTEM

- Cancer Currently Type: _____
- Cancer in the Past Type: _____
- HIV/Hepatitis
- Herpes, Cold Sores
- Fungal Infections Toes
- Lymph Nodes Swollen
- Metallic Taste in Mouth
- Mental Fog
- Kidney / Bladder Infections

SKELETAL SYSTEM

- Muscle Pain
- Muscle Cramps
- Sore Joints
- Fibromyalgia
- Arthritis
- Low Bone Density
- Headaches ___/Month

SKIN

- Eczema Psoriasis
- Dry Oily Fungal

SMOKING

- Tobacco ___/Day For ___ Years
- Marijuana ___/Week
- Other Recreational Drugs

Women Only

- Days Since Last Period
- PMS
- Birth Control
- Pregnant Breastfeeding
- Menopausal Since _____
- HRT Since _____
- Cysts, Fibroids in _____
- Breast Augmentation
- Breast Tenderness

DIET

- Vegetarian
- Vegan
- Coffee ___ Cups/Day
- Tea ___ Cups/Day
- Water ___ Cups/Day
- Cheese
- Milk
- Yogurt, plain
- Yogurt, flavored
- Fruit ___ Servings/Day
- Fruit Juice
- Soft Drinks
- Energy Drinks
- Alcohol ___ Drinks/Day
- Wheat Gluten Free
- Soy
- Salt Sugar
- Honey
- Maple Syrup
- Agave
- Artificial Sweeteners
- Nuts
- Seeds
- Animal Protein
- Junk Food
- %Raw Food Daily
- Dental Fillings
- Root Canals

"I am willing to change my diet"

How true is this statement?

___/10

This form should be placed in the patient's medical record

PATIENT TOXIN REPORT

Patient Name: _____

Date: _____

ENVIRONMENTAL TOXIN TEST:

1. Do you have amalgam fillings? Yes No
 If yes, approximately how many do you have? _____

 Have you had any amalgam extractions? Yes No
 If yes, when, and how many? _____

2. Do you know whether you mother had any amalgam fillings before you were born? Yes No
 Were you breastfed? Yes No

3. Do you eat fish regularly? Yes No
 When was the last time you ate fish? Days _____ Weeks _____ Months _____

4. Any comments on your home/work environment? _____
 Exposures to any toxins?: _____
 Other notable issues? (*Computers, cell phones, sleeping close to alarm clocks, heating blankets, etc*): _____

5. What supplements are you taking, if any?

6. Do you smoke? Yes No
 If yes, when was the last time you smoked

DETOXIFICATION CAPACITIES:

Very Low				
Low				
Medium				
Normal				
	Date #1: ___/___/___	Date #2: ___/___/___	Date #3: ___/___/___	Date #4: ___/___/___

CONSENT TO TREATMENT FOR LIVE BLOOD ANALYSIS

Name: _____ Date: ____/____/____
(Last, First)

Date of Birth: ____/____/____ Referred from?: _____

Address: _____ Phone Number: _____

I, the undersigned, hereby confirm that I am here, on this and any subsequent visit, solely on my own behalf and not as an agent for any federal, provincial, municipal, or professional agency on a mission of entrapment or investigation.

I acknowledge and agree that I understand that Laurie Pavtis, DC is not:

- Presenting herself as able to treat, diagnose, operate, or prescribe for any human disease, pain, injury, disability, or physical condition,
- Offering to undertake by any means or method to diagnose, treat, operate, or prescribe for any human disease, pain, injury, disability or physical condition,
- And, cannot and will not give medical advice.

I confirm that all information from, or communication with, Laurie Pavtis, DC. is at my own request with full knowledge of the particulars; and that no guarantees have been made to me concerning the results, that may be obtained as a result of my consultation with Laurie Pavtis, DC. All information is held in the strictest confidence and is for the sole purpose of this session only.

I confirm and acknowledge that any supplements I purchase from Nevy Health are not returnable.

I ACKNOWLEDGE AND AGREE TO NEVY HEALTH'S FINANCIAL POLICY AND "NO SHOW" POLICY. THAT IF I AM LATE, MISS, OR "NO-SHOW" AND APPOINTMENT THAT I WILL BE RESPONSIBLE FOR A "NO-SHOW" APPOINTMENT FEE.

I UNDERSTAND THAT A TWENTY-FOUR (24) HOUR NOTICE IS REQUIRED FOR ALL CANCELLATIONS. IF A NOTICE IS NOT GIVEN I WILL BE RESPONSIBLE FOR EITHER: A \$125.00 FEE FOR AN INITIAL VISIT OR A \$85.00 FEE FOR ANY FOLLOW-UP SESSIONS.

I UNDERSTAND THAT IF I AM OVER 10 MINUTES LATE FOR MY APPOINTMENT THAT I WILL BE CHARGED A LATE FEE AND MY APPOINTMENT WILL BE RESCHEDULED FOR A LATER DATE / TIME.

Patient Printed Name: _____ Date: _____

Patient Signature (or Parent/Guardian, if minor) _____

If a patient is not yet 18 years old, a parent or guardian must sign.

This form should be placed in the patient's medical record