Men's Patient Health Questionnaire

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

__Autoimmune diseases (Z13.228)
__Susceptibility to infections (Z00.00)
__Slow wound healing (T81.30)
__Decreased stamina (R53.1)
__Tobacco use (F17.210)
__Daily alcohol consumption (F10.99)
__Prescription medication use (Z79.899)
__Constipation (<1 movement/day) (K59.00)
__Gas / bloating (R14.0, R14.3)
__Indigestion / Heartburn (R12)
__Food cravings (R63 2)
__Irritable bowels (K58.9, K52.29)
__Iron deficiency/Anemia (D50.8, D50.9)
__Nutritional Anemia (D53.9)
__Kidney disease (N18.9)
__Fatty liver disease (K76.9)
__Gall bladder attacks (80.21)
__Infrequent morning erections (R68.82)
__Sexual thoughts (<2-3 times a month) (F52.9)
__Testicular hypofunction (E29.1)
__Erectile dysfunction (N52.9)
__Hormonal disorder, unspecified (E34.9)
__Sadness (R45.2)
__Low energy (R53.82)
__Fatigue (R53.82)
__Inability to walk more than I km (R53.81)
__Decreased flexibility-can't bend or kneel (M25.60)
__Not able to engage in vigorous activity (R53.1)
__Low motivation levels (R45.84)
__Decreased mental sharpness (R41.840)
__Fertility problems (E29.9)
__Excessive / chronic stress (R45.7)
__Mood fluctuations (R45.86)
__Irritable (R45.1)
__Anger outbursts (R45.4)
__Depressed (F32.9)
__Anxiety (R45.82, F41.1)
__Foggy thinking / disorientation (R41,840)
__Need caffeine to get going (R53.83)
__Morning fatigue (G47.9)
__Feel run down (R40.0)
__Feel wired before bed (G47.9)
__Low Vit D (E55.9)
__Chronic pain (G89.29)
__Elevated prostate specific antigen (R97.2)
__Lung disease (R06.02)
__Other specified abnormal findings of blood chemistry (R79.89)
__Snoring while sleeping (R06.83, G47.33)
__ Insomnia (G47.00)
__Osteoporosis / brittle bones (M81.0)
__Osteoarthritis (M15.9)
__Memory loss (R41.3)
__Diabetes / pre-diabetes (E11.8. R73.01)
__Abnormal blood sugar (R73.09)
__Decreased sweating (E88.9)
__Recent weight gain (R63.5)
__ Abnormal Weight Loss (R63.4)
__ Abdominal Pain (R10.9)
__Pigmented skinfolds (E88.81)
__Skin tags (fleshy profusion) (E88.81)
__Gout (E79.0)
__Cancer
__Varicose veins (I83.90)
__History of blood clots (I80.299)
__Prostate problems (N40.0)
__Decreased urine flow (R39.19)
__Increased urinary urge (R39.19)
__Decreased muscle mass (R53.1)
__Feeling burnt out (R53.83)
__Inability to lose weight (E66.3)
__Water retention (R60.9)
__Sleep disturbance (G47.00)
__Fatigue / drowsiness (R53.83. R40.0)
__Dark circles / bags under eyes (R53.83)
__HypoThyroid (E03.9)
__Nontoxic goiter (E04.9)
__ Disorder of Thyroid (E07.9)
__Leg pain (M79.609)
__Back pain (M54.89)
__Joint pain (M25.50)
__Numbness/tingling (R20.2)
__Using steroid medication (E24.9)
__Purple / pink stretch marks (E24.9)
__Excess belly hip fat (E28.0. E66.3. E66.0)
__Headaches (G44.229)
__Cold hands and feet (E88.9)
__Using pain / anxiety medication (F11.99)
__Eczema (L30.9)
__Psoriasis (L40.9)
__Thinning hair (L64.9)
__Shortness of breath (R06.02)
__Other specific arthropathies (M12.80)
__Chronic kidney disease, unspecified (N18.9)
__Fibromyalgia (M79.7)
__High blood pressure or medication use (I11.9, I10)
__Abnormal cholesterol or medication use (E78.5)
__Heart disease (I70.90)
__History of stroke / TIA (G45 9, I63.9)
__Family history of heart disease (Z82.49)
__Family history of diabetes (Z83.3)
__Large waist circumference (high risk >40') (E88.81)
__Recreational drug use (F12.99)
__Asthma / Wheeze (J45.909, R06.2)
__Chronic cough (R05)
__Excessive Thirst (R63.1)
__Dry mouth (R68.2)
__Sinus congestion (R09.81)
__Excess sweating (R61)
__Heart palpitations (R00.2)
__ Shortness of Breath (R06.02)
__Using hormone medication (Z79.3)
__Increased back hair (L68.0)
__Excess hair loss (L64.9)
__Excess body odor (R46.0)
__Swelling of feet / ankles (R60.9)
__Migraines (G43.0)
__Low blood pressure (R03.1)
__Using antidepressant medications (F32.9. F13.29)
__Dry / rough skin (R23.4)
__Thin skin / poor elasticity (R23.9)
__Food allergies (T78.40)
__Hive / itchy skin (L50.9)
__Skin breakouts / flares (R21)
__Dark skin discolorations around neck (E88.1)
__Increased wrinkles (R23.9)
__Acne / oily skin (L70.9)
__Immune or hormone skin cream use (Z79.3)
__Sugar cravings (E63.1)
__Recent / pending surgery/procedure (Z01.818)
__Heart failure, unspecified (I50.9)
__Intestinal malabsorption, unspecified (K90.90)
__Enlarged prostate without lower urinary tract symptoms (N40.0)
__ Seasonal Allergies/Rhinitis (J30.9, J30.2)

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: _____

Pentz Health Services LLC dba Nevy Health

CURRENT SYMPTOMS – CONCERNS

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

Pentz Health Services LLC dba Nevy Health

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, seeping 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:___/___/_____

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

Pentz Health Services LLC dba Nevy Health

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