Solutions Pharmacy
Compounding you can Trust

Please answer the following questions: Date:_____

Patient name: _____DOB ____/____/____ Cell: (_____)_____-_____

Address: _____ City: _____ St _____ Zip: _____

Doctor: _____ Phone: (_____)_____-_____

1. Describe your health issue. (Diagnosis: Pre/Post COVID-19, Fibromyalgia, Hashimoto's, Lupus, Lyme's, Rheumatoid Arthritis, Multiple sclerosis ect) _____
2. How long have you been suffering? _____ months _____ years
3. What are your top 5 complaints _____ _____ _____ _____ _____
4. Rate your pain (on a scale of 1-10 with 10 being excruciating pain) _____
5. Describe your overall health. _____ _____
6. Would you like a to set up a consult with one of our pharmacists to see how LDN may help you? _____
7. What medications are you currently taking: _____, _____, _____, _____, _____, _____, _____, _____, _____, _____

Please check current health issues

Health Issue	√	Health Issue	√
Bladder Urgency		Diabetes	
Bladder Retention		Neuralgia	
Sexual Dysfunction		Numbness	
Bowel Control		Itching	
Constipation		Blurred Vision/Double	
Memory/Concentration		Migraine Headaches	
Depression		Sleep Disturbance/Insomnia	
Dizziness		Restless Legs	
Mobility		Fatigue	
Muscle Spasm		Muscle Strength	
Anxiety		Chronic Pain	

8. Would you like to try in our LDN Program which entails: (30 minute consultation, prescription request sent to your provider for LDN therapy, Follow-up consultation by phone at 3 months, Follow-up information sent to your provider, Follow-up consultation by phone at 6 months, any dosage adjustment needed we will contact your provider for you.) ☐ Yes ☐ Not at this time