Solutions Pharmacy
Compounding you can Trust

Patient Information

Please answer the following questions: Date:_____

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

Address: _____ City: _____ St _____ Zip: _____

Doctor: _____ Phone: (_____)_____-_____ Fax: (_____)_____-_____

1. Describe your health issue. (Diagnosis: Long COVID-19, Fibromyalgia, Hashimoto's, Lupus, Lyme's, Rheumatoid Arthritis or Osteoarthritis, 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 our LDN Specialist or one of our pharmacists to see how LDN may help you? ____ Yes _____ Not at this time
7. What medications and supplements are you currently taking: _____, _____,
   _____,_____, _____, _____,
   _____, _____, _____, _____,

Please check current health issues

Health Issue	√	Health Issue	√
Constipation		Anxiety	
Irritable bowl		Depression	
Bloating or excess gas		Memory/Concentration	
Skin Itching		Migraine Headaches	
Muscle Spasm		Cold hands and feet	
Numbness		Dizziness	
Restless Legs		Hand or Thumb pain	
Loss of Muscle Strength		Hip pain	
Poor Mobility		Joint Pain	
Fatigue		Chronic Pain	
Sleep Disturbance/Insomnia		Neuropathy 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, any dosage adjustment needed we will contact your provider for you.) ☐ Yes ☐ Not at this time