



**CONFIDENTIAL AUTO-IMMUNE PATIENT EVALUATION**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Desired Weight: \_\_\_\_\_

Occupation: \_\_\_\_\_ Hobbies: \_\_\_\_\_

How often and how much?

- Do you use tobacco?  Yes  No \_\_\_\_\_
- Do you use alcohol?  Yes  No \_\_\_\_\_
- Do you use caffeine?  Yes  No \_\_\_\_\_
- Do you exercise?  Yes  No \_\_\_\_\_

How long have you exercised? (months/years) \_\_\_\_\_

Type of exercise preferred? \_\_\_\_\_

If yes, please elaborate (dates/frequency):

- Have you ever had a panic attack?  Yes  No \_\_\_\_\_
- Do you have OCD?  Yes  No \_\_\_\_\_
- Any diagnosis of mental illness?  Yes  No \_\_\_\_\_
- Ever had a head injury/concussion?  Yes  No \_\_\_\_\_

How frequent are your bowel movements? \_\_\_\_\_

Typical # of hours of sleep per night: \_\_\_\_\_ Normal bedtime: \_\_\_\_\_

Uninterrupted?  Yes  No Time and reason for interruption: \_\_\_\_\_

Do you wake rested or tired (even when getting 7-8 hours of sleep)? \_\_\_\_\_

Are you or have you ever been a night shift worker?  Yes  No

If yes, please describe when and for how long: \_\_\_\_\_

My diet is:

- \_\_\_\_\_ Super healthy
- \_\_\_\_\_ Mostly healthy
- \_\_\_\_\_ Needs work
- \_\_\_\_\_ Terrible

What would you like to change about your current dietary choices? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Name: \_\_\_\_\_

Allergies: Please list any allergies and describe the reaction that occurred.

Drugs: \_\_\_\_\_

Foods: \_\_\_\_\_

Other: \_\_\_\_\_

Over-the-Counter Medication History: Please list all non-prescription medications that you are taking. (Include vitamins, herbals, and supplements): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CBD/THC Use: Please list any products used and frequency: \_\_\_\_\_

Medical Conditions/Diseases: Please list any conditions/diseases that you have been diagnosed with or suffer from. (Examples include heart disease, high blood pressure, depression, ulcers, arthritis, insomnia, etc.).

\_\_\_\_\_

\_\_\_\_\_

Have you ever tested positive for Epstein-Barr virus?  Yes  No

If yes, please elaborate (dates/current status): \_\_\_\_\_

Current Prescription Medications: Trust. Quality. Partnership. Healthy Outcomes.

Medication Name and Strength	Date Started	How Often per Day	Medical Condition Being Treated
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<u>Current Vitamins and Supplements:</u>	Date Started	Date Stopped	Reason
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

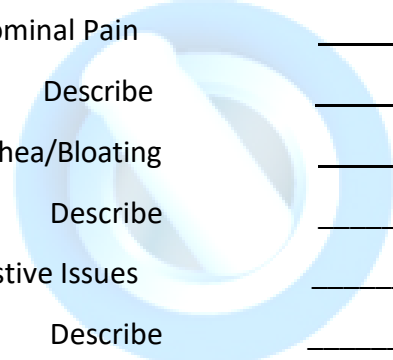
I have a family history of autoimmune disease?  Yes  No

I have had issues with chronic bacterial, fungal or viral infections  Yes  No

Explain \_\_\_\_\_

Patient Name: \_\_\_\_\_

	Absent	Mild	Moderate	Severe
Fatigue	_____	_____	_____	_____
Describe	_____			
Joint Pain/Swelling	_____	_____	_____	_____
Describe	_____			
Muscle Pain	_____	_____	_____	_____
Describe	_____			
Neuropathy	_____	_____	_____	_____
Describe	_____			
Skin Problems	_____	_____	_____	_____
Describe	_____			
Abdominal Pain	_____	_____	_____	_____
Describe	_____			
Diarrhea/Bloating	_____	_____	_____	_____
Describe	_____			
Digestive Issues	_____	_____	_____	_____
Describe	_____			
Bowel Disorders	_____	_____	_____	_____
Describe	_____			
Recurring Fever	_____	_____	_____	_____
Describe	_____			
Swollen Glands	_____	_____	_____	_____
Describe	_____			
Impaired Coordination	_____	_____	_____	_____
Describe	_____			
Hair Loss	_____	_____	_____	_____
Describe	_____			
Weight Gain	_____	_____	_____	_____
Describe	_____			


**ADKOA**  
 Pharmacy  
 Trust. Quality. Partnership. Healthy Outcomes.

Patient Name: \_\_\_\_\_

	Absent	Mild	Moderate	Severe
Weight Loss	_____	_____	_____	_____
Describe	_____			
Dry Mouth	_____	_____	_____	_____
Describe	_____			
Dry Eyes	_____	_____	_____	_____
Describe	_____			
Painful Menses	_____	_____	_____	_____
Describe	_____			
Hormone Imbalance	_____	_____	_____	_____
Describe	_____			

**Have you ever been diagnosed or experienced symptoms associated with the following conditions:**

Celiac Disease	_____	_____	_____	_____
Describe	_____			

Crohn's Disease	_____	_____	_____	_____
Describe	_____			

IBS	_____	_____	_____	_____
Describe	_____			

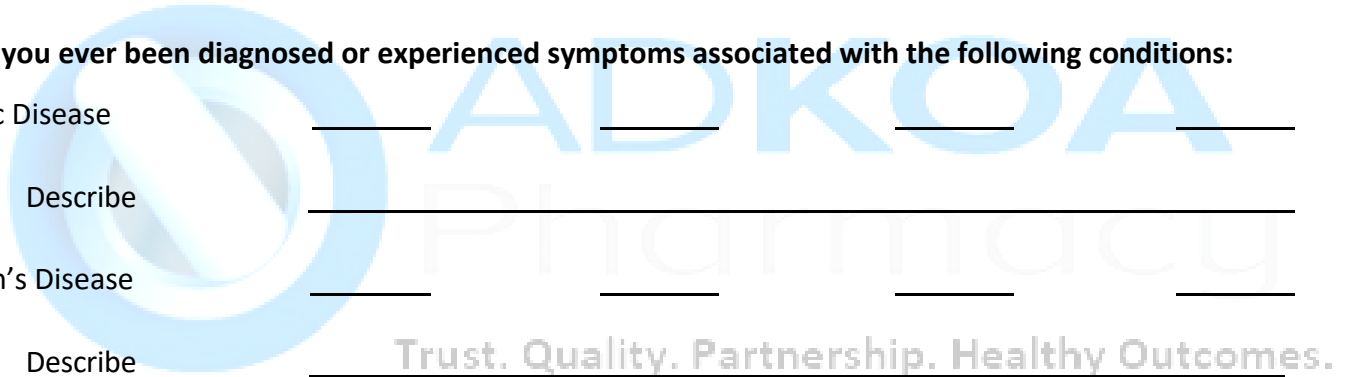
Lupus	_____	_____	_____	_____
Describe	_____			

Hashimoto's Disease	_____	_____	_____	_____
Describe	_____			

Multiple Sclerosis	_____	_____	_____	_____
Describe	_____			

Rheumatoid Arthritis	_____	_____	_____	_____
Describe	_____			

Sjogren's Syndrome	_____	_____	_____	_____
Describe	_____			



**THIS PAGE FOR FEMALE PATIENTS ONLY**

Patient Name: \_\_\_\_\_

How many pregnancies have you had? \_\_\_\_\_ How many children? \_\_\_\_\_

Any interrupted pregnancies?  Yes  No

If yes, please explain: \_\_\_\_\_

If you have been pregnant, how did you feel while pregnant? Please explain (ex: great, horrible, to be expected) \_\_\_\_\_

Have you had a tubal ligation:  Yes  No If yes, date of surgery: \_\_\_\_\_Have you had a hysterectomy?  Yes  No If yes, date of surgery: \_\_\_\_\_

Reason for hysterectomy/diagnosis: \_\_\_\_\_

Do your ovaries remain?  Yes  NoHave you had an endometrial ablation?  Yes  No If yes, date of surgery: \_\_\_\_\_

Date of COVID infection/vaccine: \_\_\_\_\_

Do you have a family history of any cancers or osteoporosis? Please list the family member(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any of the following tests performed?

Mammography  Yes  No Date: \_\_\_\_\_ Outcome: \_\_\_\_\_PAP smear  Yes  No Date: \_\_\_\_\_ Outcome: \_\_\_\_\_Bone density  Yes  No Date: \_\_\_\_\_ Outcome: \_\_\_\_\_

What age did your period start? \_\_\_\_\_ How many days is/was your cycle (Example: 28): \_\_\_\_\_

Is/was your menstrual flow heavy or light? \_\_\_\_\_ Any clots?  Yes  No

At what age (if known) did your mother, maternal aunts, sisters go through menopause?

\_\_\_\_\_

Have you ever had what YOU would consider to be abnormal cycles?  Yes  No

Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

When was your last period? \_\_\_\_\_ How many days did it last? \_\_\_\_\_

Do you or have you ever suffered from Premenstrual Syndrome (PMS) symptoms?  Yes  No

Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



Patient Name: \_\_\_\_\_

What are your goals for taking starting on Low Dose Naltrexone?

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

When in your lifetime did you feel the best? (Please explain with details)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Doctor who we should contact for this therapy:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street
City
State
Zip

\*\*\* Please include a copy of all relevant lab work that you have recently obtained.

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