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:

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

Current Vitamins and Supplements:

	Date Started	Date Stopped	Reason

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	_____			

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 ☐ No

Have 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.