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INITIAL PATIENT INTAKE FORM

Filling out this form does not guarantee an approval or recommendation for the use of medical cannabis.

Name: ____ **Date:**______________

Date of Birth: _____________________________ **Gender:** ___ Male ___ Female

Address: ____

City: _____________________________ **State:** ____________ **Zip:** __________________

Phone: __________________________ **Cell:** ____________________________

Email: __________________________________

Social Security Number ____

CT Drivers License ID#: ___________________________________ **Expiration Date:** _________

WHERE DID YOU HEAR ABOUT US?____

For which diagnosis were you approved for use of medical marijuana? (Select one or more)

- ☐ **Cancer:**__________________________
- ☐ **Cachexia/ Wasting Syndrome**
- ☐ **Multiple Sclerosis**
- ☐ **Parkinson's Disease**
- ☐ **Post-Traumatic Stress Disorder**
- ☐ **Ulcerative Colitis**
- ☐ **Crohn's Disease**
- ☐ **Glaucoma**
- ☐ **HIV or AIDS Positive**
- ☐ **Epilepsy**
- ☐ **Sickle Cell Disease**
- ☐ **Fabry's Disease**
- ☐ **Severe Psoriatic Arthritis with Severe Psoriasis**
- ☐ **Post Laminectomy Syndrome with Radiculopathy**
- ☐ **Damage to the Nervous Tissue of the Spinal Cord with Objective Neurological Indication of Intractable Spasticity**
- ☐ **Complex Regional Pain Syndrome (CRPS)**

What symptoms are you currently experiencing that you are looking to get relief from by using Medical Marijuana? (Select any that apply)

☐ Nerve Pain
☐ Muscle Pain
☐ General Pain
☐ Migraine
☐ Anxiety
☐ Depression
☐ Nightmares
☐ General Insomnia
☐ Difficulty Falling Asleep
☐ Difficulty Staying Asleep
☐ Ocular Pressure
☐ Nausea
☐ Tremors
☐ Seizures
☐ Poor Appetite
☐ Abdominal Cramping
☐ Hyperactive Bowels
☐ Other____________________

What is your preferred method(s) of using Medical Marijuana? (Select as many as apply)

Inhaled: ☐ Vapor ☐ Joint ☐ Pipe ☐ Water Pipe

Ingested: ☐ Tea ☐ Capsules ☐ Butter/Oil ☐ Tincture ☐ Edibles ☐ Other____________________

Suppository: ☐ Rectal ☐ Vaginal

Topical: ☐ Tincture ☐ Cream/ Ointment ☐ Poultice ☐ Parabath ☐ DMSO ☐ Spray

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What sort of Medical Marijuana are you looking to obtain? (Circle)

INDICA SATIVA HYBRID

What strains of marijuana have you tried in the past, with what results?

Strain	Dosage Form (flower, oil, edible, etc)	Delivery Device (smoked via bowl or water pipe, vaporizer, etc)	Estimated Daily Dose (in grams, joints, puffs, etc)	Did you experience clinical relief?	Side effects experienced

Are you currently under the care of a physician? Yes____ No____

If yes, what is the name of your primary care physician?____

Physician's Address: __________________________________**Phone Number:**__________________________

If no, please provide us with the name of the physician or medical facility that you visited for your medical condition(s)____

Have you been evaluated for the use of medical marijuana by any other physician in the past?

Yes___ No___

If yes, please give name of doctor, date seen and condition for which cannabis was approved

____

Have you been evaluated and denied a medical marijuana recommendation? Yes___ No___

If yes, please explain____

Are you currently enrolled or attending school? Yes ___ No ___

Do you have children? Yes ___ No ___ **If yes, how many?** ___________________________

Female Patients:

Are you pregnant? Yes ___ No ___ **Are you planning a pregnancy?** Yes___ No___

Have you been arrested or charged with a crime in the last 2 years? Yes ___ No ___

If yes, please specify ____

Are you currently on parole or probation? Yes ___ No ___ **Signature:** ___________________________________

Are you currently attending or have you ever attended any drug or substance abuse or rehabilitation program? Yes ___ No ___

If yes, what was the name of program? ____

Have you ever been treated for symptoms of depression, attempted suicide or had any other mental problem? Yes ___ No ___

If yes, explain ____

Have you ever been prescribed or taken medication for any of these problems? Yes ___ No ___

If yes, what medications ____

If applicable, what is the name of your mental health physician? ____________________________________

Do you currently smoke tobacco? Yes ___ No ___

If yes, how often and how many per day? ____

Do you currently use marijuana? Yes ___ No ___

If yes, how much do you use per week? ____

Are you taking any medications? Yes ___ No ___

If yes, name the medication(s) and dosages below.

Medication Name (including non-prescription medications, herbal supplements and vitamins)	**Dose (mg)**	**Frequency**	**Date of Last Dose Taken**	**Prescriber Name**
Example: Percocet	5/325	4 x per day	01/22/2015	Dr. Emmett Brown

Do you have any allergies to medicine? Yes ___ No ___

If yes, please list medicine: ____

Have you ever been hospitalized? Yes ___ No ___

If yes, give dates and details: ____

Have you ever had surgery? Yes ___ No ___

If yes, give dates and details: ____

Please indicate if you or your immediate family members have had any of the following problems:

☐ **Check here if none**

☐ Asthma ☐ High Blood Pressure ☐ Diabetes ☐ Hepatitis Substance Abuse ☐ Heart Disease

☐ Stroke ☐ Tuberculosis ☐ Alcoholism ☐ Cancer Kidney Disease ☐ Sinusitis

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Please indicate if you have had any of the following symptoms consistently:

☐ **Check here if none**

☐ Sleeplessness ☐ Chest Pain ☐ Constipation ☐ Nausea ☐ Diarrhea ☐ Loss of Appetite

☐ Stomach Pain ☐ Depression ☐ Vomiting ☐ Anxiety ☐ Rectal Pain ☐ Swollen Ankles

☐ Skin Rashes ☐ Palpitations ☐ Headaches ☐ Chronic Pain ☐ Fever ☐ Muscle Spasms

☐ Coughing ☐ Heart Burn ☐ Seizures ☐ Eye Problems ☐ Blood in Bowels ☐ Difficulty Swallowing

Describe any other health problems that occur frequently with you or in your family: __________________

____

____

____

I hereby declare that I have completely and truthfully disclosed all information regarding my medical condition and attest that I am not a member, employee or agent of any media or law enforcement agency. It is illegal for a patient to film or record in this office with video camera, cell phone or any other recording device whether still image, video or audio. This is a direct violation of HIPAA regulations and patient/doctor confidentiality. I am aware that my approval or recommendation may be revoked at any time if I have perjured or misrepresented myself or my condition.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT

Patient Signature:____ **Date:**______________________

Physician Reviewed:____ **Date:**______________________

Informed Consent: Risks and Side Effects, Release of Liability

Name: ____ Date: ______________

Date of Birth: ______________

<u>Please read each item below and initial in the space provided to indicate that you understand the information regarding the risks and side effects of using cannabis. I agree to tell the attending physician if I do not understand any of the information provided.</u>

- I understand that the cultivation, possession and use of cannabis, even for medical purposes, are currently illegal under **federal** law. ________

- I understand that cannabis is not regulated by the U.S. Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities and or contaminants. _______

- I understand that the attending physician, including the physician's employees, may not provide information regarding where medicinal cannabis might be obtained. Doing so would be a violation of **federal** law. ______

- The efficacy and potency of cannabis varies widely depending on the cannabis strain and ingestion method. Under federal law, the attending physician is unable to discuss dosage. _________

- Symptoms of a cannabis overdose include, but are not limited to, nausea, vomiting, numbness, irregular heartbeat, drowsiness, and anxiety. ________

- In the event of an overdose, I am advised to lie down, relax, and rest. If the symptoms persist, I agree to contact the attending physician or call 911 if needed. ________

- Cannabis smoke contains tars and may include carcinogens (chemicals that can cause cancer) that have potentially harmful effects including increasing the risk of respiratory diseases and cancer of the lungs, mouth and tongue. _______

- There is little known regarding how cannabis may, or may not, react with other pharmaceutical or herbal medications. _________

- Use of cannabis may result in higher and higher dosages due to user's development of a tolerance to cannabis. ________

○ I understand that the use of cannabis may affect my coordination and cognition. I agree not to operate heavy machinery, drive or engage in potentially hazardous activities while using cannabis.________

○ I understand that it is against the law to drive a vehicle while using marijuana and that I can get a DUI for driving under the influence. ________

○ The use of a vaporizer, as an ingestion method, can substantially reduce the potentially harmful effects of smoking cannabis. _________

○ Cannabis may be ingested in a tincture or edible form that eliminates some of the potentially harmful effects of smoking. _________

○ I understand that any of the following side effects can result from the use of cannabis: ___________

- ❖ Short term memory loss
- ❖ Low blood pressure
- ❖ Anxiety/Nervousness
- ❖ Sedation
- ❖ Irregular heart beat
- ❖ Difficulty completing complex tasks
- ❖ Dry mouth
- ❖ Inability to concentrate
- ❖ Slower reaction time
- ❖ Paranoia, psychotic symptoms (delusions)
- ❖ Suppression of immune system
- ❖ Poor physical coordination
- ❖ Talkativeness
- ❖ Hunger
- ❖ Impairment of motor skills
- ❖ Loss of appetite reaction time, coordination
- ❖ Dizziness
- ❖ Cough
- ❖ Dependency
- ❖ Confusion
- ❖ Impaired vision
- ❖ Feeling of euphoria
- ❖ Drowsiness
- ❖ Headache
- ❖ Nausea/Vomiting
- ❖ Fatigue
- ❖ Apathy
- ❖ Depression
- ❖ Changes in sleep patterns
- ❖ Numbness
- ❖ Laryngitis
- ❖ Bronchitis
- ❖ Shortness of breath
- ❖ Agitation/irritability
- ❖ Trouble concentrating

○ I understand that there may be benefits and risks associated with the use that have not been identified. _________

○ I agree to stop using cannabis and inform the attending physician in the event that I experience depression, have thoughts of suicide, or any other mental problems. _______

- I also agree to inform the attending physician of any anti-psychotic medication that I may be taking currently or in the future. _______

- There is a possibility that cannabis may worsen schizophrenia in persons predisposed to that disorder. __________

- I agree to stop using cannabis and inform the attending physician if I am experiencing any negative side effects that may be caused from my therapeutic use of cannabis. _________

- There is the possibility of experiencing withdrawal symptoms when I stop using cannabis. I understand that these withdrawal symptoms can include, but are not limited to, depression, irritability, insomnia, loss of appetite, and tiredness. _______

- I understand that cannabis is not recommended while under the influence of alcohol. _______

- I hereby state that I fully understand the potential risks and side effects related to the use of cannabis as described above. ________

- Furthermore, in using cannabis therapeutically, I accept full responsibility in assuming the risks and side effects related to its use. ________

- I agree that the attending physician and his/her principals, agents, and employees, shall not be held responsible for any harm resulting to me and/or other individuals as a result of my medicinal use of cannabis. __________

Patient Signature:____ **Date:_____________________**

Physician Reviewed:____ **Date:_____________________**