HIGHER MED
ELEVATE YOUR EXPECTATIONS

Registration Form

Patient Information

Full Name (as spelled on your CT ID)

Date of Birth (MM/DD/YYYY)

Street address

Street address line 2

City

State

Zip Code

E-mail address

Primary Care Provider

Past medical history (please list any medical conditions you've been diagnosed with):

Current Medications or Supplements:

Medication Allergies

Do you use tobacco? If so, how often?

Do you drink alcohol? If so, how often?

Do you use any other illicit drugs? How often?

Please list your qualifying diagnosis for a medical marijuana card (if visit is for PTSD evaluation, please type 'PTSD eval' below)

What other treatments have you tried for this medical condition? (medication, therapy, etc.)

How effective were these treatments in helping your symptoms? (not helpful, mild relief, moderate relief, significant relief)

How effective has medical marijuana been in helping your symptoms?

Are you experiencing any side effects from medical marijuana?