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Patient Registration Form

Date _____

Completing this form does not guarantee an approval for the use of medical marijuana

Name:_____ Date of Birth _____

Address _____
Street Apt # City State Zip Code

Phone _____ Cell _____ Email _____

Sex: Male__ Female__ Marital Status: S__ M__ D__ W__ Do you have children? Yes__ No__ Ages?_____

Soc. Sec. # _____ CT Drivers License ID# _____ Exp Date _____

Occupation _____ Are you a federal employee? Yes __ No __

Referring physician: _____
Address _____ Phone _____

Primary care physician: _____
Address _____ Phone _____

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

___Cancer
___Cachexia/ Wasting Syndrome
___Chronic Pain > 6 months associated with a chronic condition
___Complex Regional Pain Syndrome (CRPS)
___Crohn's Disease / Ulcerative Colitis
___Interstitial Cystitis
___Intractable Headache Syndrome
___Multiple Sclerosis
___Neuropathic Facial Pain
___Neuropathic Pain associated with Degenerative Spinal Disorders
___Neuropathic Pain, Intractable
___Parkinson's Disease
___Post-herpetic Neuralgia
___Post Laminectomy Syndrome with Radiculopathy
___Psoriatic Arthritis w/ Severe Psoriasis
___Rheumatoid Arthritis
___Spasticity or Neuropathic Pain associated with Fibromyalgia
___Spinal Cord Injury with Spasticity
___Vulvodynia

Have you ever been evaluated for the use of medical marijuana in the past? Yes __ No __
If yes, please provide name of doctor, date seen, and condition for which cannabis was approved. _____
_____

Have you ever been denied the use of medical marijuana? Yes __ No __
If yes, please explain _____
_____

What symptoms are you currently experiencing that you are looking to get relief from by using Medical Marijuana?

___Anxiety
___Abdominal Cramping
___General Pain
___Hyperactive Bowel
___Migraines
___Muscle Pain
___Nausea
___Nerve Pain
___Ocular Pressure
___Poor Appetite/ Weight Loss
___Seizures
___Tremors
___Other _____

Have you had any of the following symptoms consistently? Check here if none ____

__Anxiety
__Arthritic Pain
__Back Pain
__Blood in Bowels
__Chest Pain
__Chronic Pain
__Constipation
__Coughing
__Difficulty Swallowing
__Depression
__Diarrhea
__Eye Problems
__Fever
__Headaches
__Heartburn
__Loss of Appetite
__Muscle Spasms
__Nausea/Vomiting
__Neck Pain
__Palpitations
__Rectal Pain
__Seizures
__Skin Rashes
__Sleeplessness
__Stomach Pain
__Swollen Ankles
__Other _____

Have you or your immediate family members had any of the following conditions? Write S for Self or F for Family
Check here if none ____

__Alcoholism
__Asthma
__Cancer
__COPD
__Diabetes
__Heart Disease
__Hepatitis
__High Blood Pressure
__Kidney Disease
__Liver Disease
__Sinusitis
__Stroke
__Substance Abuse
__Tuberculosis
__Other _____

Describe any other health problems that occur frequently with you or your family_____

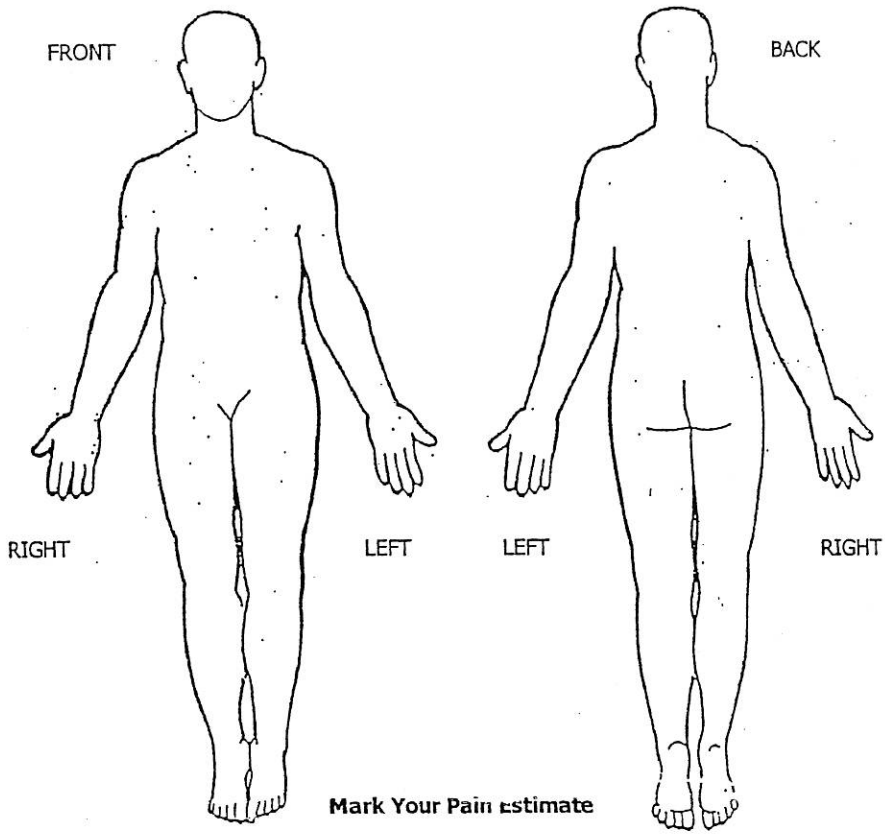
_____

_____

_____

Use the body Diagram below to indicate the location of you pain.
Mark the areas on the drawing with the symbol that best describes the sensation you feel

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	SHOOTING	THROBBING	CRAMPING
AAAA	=====	OOOO	.....	/////	------>	XXXXX	CCCC
AAA	===	OOO	.....	///	----->	XXXX	CCC



No Pain (0)_____(10) Intolerable

What aggravates the pain? _____

When is the pain worse? _____

What is the frequency of the pain?_____

What other symptoms are you experiencing? _____

Prior treatment for this problem?_____

_____

Diagnostic Procedures (Cat Scan, MRI, Xray) _____

Female Patients: Are you pregnant or breastfeeding? Yes __ No __ Planning a pregnancy? Yes __ No __

Do you currently smoke tobacco? Yes __ No __
If yes, how much per day? _____

Do you currently use marijuana? Yes __ No __
If yes, how much per week? _____

Do you drink alcohol? Yes __ No __
If yes, how much per week? _____

Have you ever been treated for symptoms of depression, attempted suicide, or other mental illness? Yes __ No __
If yes, please explain _____

Have your ever been prescribed or taken medication for any of these problems? Yes __ No __
If yes, what medications? _____
Who is your mental health physician? _____

Are you taking any medications (prescription & non-prescription), herbal supplements, or vitamins? Yes __ No __
If yes, list the medication/supplement/vitamin and dosages below

Medication Name	Dose (mg)	Frequency	Date Last Taken	Prescriber Name
Example: Percoset	5/325	4 x per day	1/1/16	Dr. John Doe

Are you allergic to any medications? Yes __ No __
If yes, what medications? _____

Have you ever been hospitalized?
If yes, give dates & details _____

Have you ever had surgery?
If yes, give dates & details _____

I have completely and truthfully disclosed all information regarding my medical condition. I am aware that my approval or recommendation may be revoked at any time if I have perjured or misrepresented myself or my condition.

Patient Signature _____ Date _____

Physician Reviewed _____ Date _____

Informed Consent: Risks and Side Effects, Release of Liability

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.

Name _____ Date of Birth _____

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. FDA and therefore may contain unknown quantities of active ingredients, impurities and or contaminants. _____

The efficacy and potency of cannabis varies widely depending on the cannabis strain and ingestion method. Under federal law, the 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. _____

There is little known regarding how cannabis may or may not react with other pharmaceutical or herbal medications _____

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

I understand that any of the following side effects can result from the use of cannabis. _____

Short term memory loss
Difficulty concentrating
Difficulty completing complex tasks
Impairment of motor skills/ slower reaction time
Anxiety/Nervousness/Paranoia
Agitation/Irritability
Low blood pressure
Irregular Heartbeat
Sedation/Drowsiness/Fatigue
Change in Sleep patterns
Dizziness
Apathy
Depression

Cough/Laryngitis/Bronchitis
Shortness of Breath
Dry Mouth
Hunger
Nausea/Vomiting
Numbness
Headache
Impaired Vision
Confusion
Feeling of Euphoria
Talkativeness
Dependency

I fully understand and accept responsibility for potential risks and side effects related to the use of cannabis as stated above. _____

I understand that there may be benefits and risks associated with the used of cannabis that have not been identified. _____

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

I agree to safeguard all marijuana and marijuana-infused products from children, pets, or domestic animals _____

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

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

I agree that the physician and his 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. _____

Consultation and registration fees associated with participation in the CT Medical Marijuana Program are not covered by any health insurance plan. I am financially responsible for payment of all fees at the time of visit.

I agree that the use of cannabis is solely for the treatment of my medical condition and that distribution or sale of cannabis to another individual(s) is a criminal offense and will result in immediate termination of my participation in the CT Medical Marijuana Program.

I agree to follow-up visits at 3 and 6 month intervals, and recognize that medical marijuana registration is for a period of one year, subject to a re-registration review process.

Patient Signature _____ Date _____

Physician Reviewed _____ Date _____