Patient Information

Date

Personal Information

First Name*		Last Name*	
Email*		Phone*	
Drivers Lic. or State ID*		Date of Birth*	
Address*		Apartment #	
City*		State*	Zip Code*
Gender*	Contact Me By Text/Email/Phone	May I leave a voicemail?	Referred By

Qualify

*Do You Have Any Drug Allergies?**
Yes No

If yes, please specify below*

Current Medication (Leave Blank if None)		
Name	Dosage	Frequency

Current Weight (in pounds)

Qualifying Conditions*

Please circle the condition(s) in which you seek Medical Marijuana for.

HIV / AIDS	Glaucoma
Cancer	Seizures / Epilepsy (after two drugs failed)
Cachexia / Wasting Syndrome	Parkinson's Disease
Dystrophy / Multiple Sclerosis	Intractable (Chronic) pain
Spasticity	Crohn's Disease
PTSD	Autism Spectrum Disorder

Current Symptoms

*Review of Symptoms**

Please circle the current symptom(s) you may have. You may select multiple options.

Abdominal Pain	Mild	Moderate	Severe
Anxiety	Mild	Moderate	Severe
Joint Pain	Mild	Moderate	Severe
Muscle Spasm	Mild	Moderate	Severe
Poor Appetite	Mild	Moderate	Severe
Nausea / Vomiting	Mild	Moderate	Severe
Disturbing feelings	Mild	Moderate	Severe
Depression	Mild	Moderate	Severe
Constipation	Mild	Moderate	Severe

*Circle you level of pain.**

1 2 3 4 5 6 7 8 9 10

Do you require assistance in Activities of Daily Living?

Requires No Assistance Some Assistance Needed Complete Assistance Needed

Have you used cannabis in the past to treat you medical conditions?

Yes No

Do you smoke tobacco?

Yes No

*Do you understand that smoking is harmful to you lungs and is not medically advised?**

Yes No

*Have you had any negative / adverse reactions from cannabis use?**

Yes No NA

Preferred method of marijuana use as a medicine.

Capsules Nebulizer

Oil Extract / Concentrate Tincture

Topical Cream Vaporizer

Other

Do you have a history of mental illness?

Yes No

Do you have a history of mental illness in your immediate family: parents, grandparents, or siblings?

Yes No

Do you have a history of addiction and/or drug abuse?

Yes No

If so, please specify the drug(s).

Surgical History

Please check if any of the following activities are substantially limited or impaired (i.e. pain/weakness/impaired strength or ability) by the medical conditions for which you seek medical marijuana.

Bending	Breathing
Caring for Myself	Communicating
Concentrating	Eating
Lifting	Operation of major bodily functions
Performing manual tasks	Reading
Seeing	Sleeping
Social interaction	Speaking
Standing	Thinking
Walking	Working

Additional information that you consider relevant to the physician's evaluation:

Are you currently taking CBD oil?

Yes No

Do you experience any side effects from CBD?

Yes No NA

Are there medical records that document you medical condition(s)?

Yes No

Patient Signature_____