Cleveland Spine and Pain Management Center
New Patient/Renewal Registration Form

DATE_____ **PLEASE PRINT**

Full Name _____

Address_____Apt#_____

City_____ State_____ Zip _____

Phone Number _____ Cell _____

Social Security Number_____ DOB_____Age_____

E-Mail Address _____

Sex ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐Separated ☐ Widowed

Is visit related to an accident _____Date of Accident _____

Type of Accident ☐ Auto ☐ Home ☐ Work ☐ Other

Employer Name_____

Employer Address_____

Employer Phone Number_____

Emergency Contact Name _____

Phone Number_____Relationship_____

Patient/ Guarantor Signature:

_____Date:_____

Welcome to Cleveland Spine and Pain Management Center
Consent for Medical Evaluation Regarding Cannabis

I, (print name)_____, am at
Least the age of 18, (or the parent or guardian for the patient) and believe that I have at least one of the 21 medical conditions or symptoms listed below, as defined by the Ohio Medical Marijuana Control Program. I further believe that Medical Marijuana, also known as cannabis, may help ease my condition(s) or symptom(s). I have attempted to obtain and provide copies of my relevant medical records regarding any previously diagnosed debilitating medical condition(s) or symptom(s).

Please check the condition(s) or symptom(s) below for which you seek treatment with medical cannabis.
I have been diagnosed with - have a medical illness - or a current medical treatment that causes one or more of the following **Medical Conditions/Symptoms: (check all that apply)**

- ☐ Post-Traumatic Stress Disorder
- ☐ Inflammatory Bowel Disease
- ☐ Intractable Pain
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Spinal Cord Disease or Injury
- ☐ Ulcerative Colitis
- ☐ Traumatic Brain Injury
- ☐ Sickle Cell Anemia
- ☐ HIV
- ☐ Tourette's Syndrome
- ☐ Chronic Pain
- ☐ Glaucoma
- ☐ Fibromyalgia
- ☐ Cancer
- ☐ Crohn's Disease
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Epilepsy or another seizure disorder
- ☐ Hepatitis C
- ☐ AIDS
- ☐ Chronic Traumatic Encephalopathy
- ☐ Alzheimer's Disease

I understand that I am consulting with a physician to obtain as to whether or not I might benefit from the medical use of cannabis. In performing an evaluation of my medical condition as it relates to determining if I might benefit from medical use of cannabis, a bona fide physician-patient relationship is established for the purpose of fulfilling the physician's role as defined in the Ohio Medical Marijuana Control Program. Our physician(s) advise you to consult both with us and with your primary care provider at least once a year to re-evaluate your debilitating medical condition.

I understand if the physician's opinion is that medical use of cannabis may benefit me, the decision to use medical cannabis is still at my sole discretion as a patient. If I choose to use medical cannabis, I understand that cannabis may cause side effects, such as drowsiness, dizziness, decreased reaction time, and decreased coordination, and I must avoid hazardous activities, such as driving a vehicle and operating heavy machinery, when using medical marijuana. I understand that, as with any drug, there is a risk of dependence or addiction.

If I plan to become pregnant or breastfeed, I will tell the physician and discuss the potential risks that cannabis poses to my unborn or newborn baby.

Our physician(s) in no way imply or recommend that you purchase medicinal cannabis from any specific dispensary or caregiver.

Signature _____ Date _____

MEDICAL / SOCIAL HISTORY

1. How did you hear about Cleveland Spine and Pain Management Center? (Please be specific and write the name of the doctor, name of friend, former Pain Center patient, magazine, newspaper, radio, TV station/program or other)

_____

_____

2. If you were referred by a physician you MUST complete the following:

Is this your primary physician? Yes or No

Physician name _____

Specialty: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: (____)_____ Fax: (___)_____

What is the diagnosis that you have been given:

_____

_____

_____

3. When did your most recent symptoms begin?

_____

What was the date your pain problem began?

_____

4. What has occurred in the past 6 months to cause you to seek treatment for your condition:

_____

_____

_____

5. Was the problem due to:

- ☐ Disease process
- ☐ Work Injury
- ☐ Auto accident
- ☐ Other accident
- ☐ No apparent reason

Date of injury/accident: _____

6. What is your major problem: (Please check all that apply):

PAIN

☐ Neck	☐ Upper back	☐ Lower back
☐ Shoulder	☐ Hip	☐ Headache
☐ Knee	☐ Extremity	☐ Other_____
☐ Fibromyalgia	☐ RSD	

7. What activities are you no longer able to do, require assistance in doing, or are becoming more difficult to do because of pain?

- ☐ Self care (grooming, bathing, dressing, feeding,….)
- ☐ Home care (grocery, shopping, banking, laundry,…)
- ☐ Mobility (sitting, standing, walking, stairs,…)
- ☐ Transfer (bed, toilet, shower, wheelchair, car,…)
- ☐ Household (cleaning, cooking, yard, childcare,…)
- ☐ Vocational activities (work, school, volunteer,…)
- ☐ Avocational activities (leisure, sport, travel,…)
- ☐ Sleep
- ☐ Driving
- ☐ Other _____

8. Do you require the use of an assistive device?

- ☐ Cane ☐ Walker ☐ Wheelchair
- ☐ Brace: Type _____

9. Do you have any other medical problems? (check all that apply)

☐ Heart	☐ Lung/breathing
☐ Diabetes	☐ Hernia
☐ High blood pressure	☐ Pacemaker
☐ Ankles swell	☐ Chest pain
☐ Shortness of breath	☐ Dizzy spells
☐ Memory problems	☐ Fall easily

- ☐ Cancer: Type _____
- ☐ Currently under the care of a psychiatrist Name: _____
- ☐ Currently under the care of a psychologist Name: _____
- ☐ Other _____

10. What is your weight: _____ Height: _____

11. Please list all allergies you have: _____
_____

12. Do you smoke? □No □Yes ____ # packs/day

13. Do you use alcohol or recreational drugs?
□ Regularly □ Occasionally □ Never

14. Are you on a special diet? □ Yes □ No
If Yes, what kind: _____

15. Have you had previous treatment(s) for your current condition (check all that apply):

- **□ Physical Therapy**
- **□ Occupational Therapy**
- **□ Chiropractic**
- **□ TENS**
- **□ Biofeedback**
- **□ Psychological Counseling**
- **□ Psychiatric Treatment**
- **□ Bed Rest**
- **□ Acupuncture**
- **□ Massage**
- **□ Trigger Point Injection**
- **□ Epidural Injections**

16. List <u>all</u> surgeries you have had:

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

<u>PRICACY STATEMENT:</u>

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your protected health information may be used and disclosed by us. It also tells you how you can get access to this information. As a patient, you have the following rights: 1) the right to inspect and copy your information; 2) the right to request corrections to your information; 3) the right to request that your information be restricted; 4) the right to request confidential communications; 5) the right to report of disclosures of your information; and 6) the right to a paper copy of this notice.

We want to assure you that your health information is secure with us. Please sign below to permit us to use, disclose, and share the health information in this application ONLY with personnel in or outside our facility who may be involved in reviewing your application, making your appointments, and authorizing services. Thank you.

***Your Signature* _____**
Today's Date _____

CURRENT MEDICATIONS

Please list all medications you are taking at this time (prescribed and over the counter). Also, please list herbal products, homeopathic medicines, supplements, vitamins, or artificial sweeteners you are taking.

MEDICATION NAME	DOSAGE (mg)	# PILLS PER DAY	REASON TAKING?