**Patient Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_ Gender M F

\_\_\_New Card \_\_\_ Renewal

Acceptable Identification

(Only ONE is Required)

\_\_ Az DL or ID or one of the following:

\_\_\_ US Birth Certificate

\_\_\_ US Certificate of Naturalization

\_\_\_ US Certificate of Citizenship

\_\_Az Registry Card

\_\_Photograph Page of US Passport

ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Issue: \_\_\_/\_\_\_\_/\_\_\_\_\_

Expiration Date: \_\_\_/\_\_\_/\_\_\_\_\_

**Qualifying Conditions – Medical Records are required**

\_\_ Acquired immune deficiency syndrome (AIDS)

\_\_ Human immunodeficiency virus (HIV)

\_\_ Agitation of Alzheimer's disease

\_\_ Amyotrophic lateral sclerosis (ALS)

\_\_ Cancer

\_\_ Crohn's disease

\_\_ Glaucoma

\_\_ Hepatitis C

\_\_ PTSD

Chronic or debilitating disease/medical condition which causes:

\_\_ Cachexia or wasting syndrome \_\_ Severe nausea

\_\_ Severe and chronic pain

\_\_ Seizures, including those characteristic of epilepsy

\_\_ Severe or persistent muscle spasms, including multiple sclerosis

Residential Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Az\_\_\_\_\_\_\_\_\_\_\_\_

Street Number City Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County of Residence:

Mailing Address: \_\_ Same as Residence If not the same as the residential address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Az\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Number City Zip

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_\_\_\_ Mobile Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_ May we send you a reminder postcard for next year? **Y N**

Are you currently receiving Supplemental Nutritional Assistance? **Y N**

Requires one of the following: \_\_ Eligibility Notice \_\_ Electronic Benefits Transfer Card (Name Embossed)

Please tell us how you found out about us:

\_\_ Coppervalleymedical.com \_\_ Patient Brochure \_\_ Facebook \_\_ Social Media \_\_ Other

\_\_Referral by physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Referral by patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Referral by dispensary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following is required of all patient applications:

\_\_ Current Photograph of the Patient \_\_ Acceptable Identification

\_\_ Signed, dated “Medical Marijuana Attestation” form \_\_ Payment of the Fee (VISA, MasterCard)

\_\_ Medical Records for the past 12 months State Fee: $150 $75 (SNAP)

Office Fee: $135.00

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Date

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Severe and Chronic Pain Patients**

Severity of Pain (1-10)

What is the nature of your pain?

* Headache 1…3…6 7 8 9 10
* Neck 1…3…6 7 8 9 10
* Upper Back 1…3…6 7 8 9 10
* Mid Back 1…3…6 7 8 9 10
* Lower Back 1…3…6 7 8 9 10
* Sciatic Pain R L 1…3…6 7 8 9 10
* Knee R L 1…3…6 7 8 9 10
* Ankle R L 1…3…6 7 8 9 10
* Foot R L 1…3…6 7 8 9 10
* Shoulder R L 1…3…6 7 8 9 10
* Elbow R L 1…3…6 7 8 9 10
* Wrist R L 1…3…6 7 8 9 10
* Hand R L 1…3…6 7 8 9 10
* Abdomen 1…3…6 7 8 9 10
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1…3…6 7 8 9 10
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1…3…6 7 8 9 10
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1…3…6 7 8 9 10
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1…3…6 7 8 9 10
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1…3…6 7 8 9 10

What caused your pain?

* Motor Vehicle Accident: Date\_\_\_\_\_\_\_\_\_\_\_\_\_
* Work Accident: Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Sports Injury: Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Congenital/Birth
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen other doctors for this? Y N

* If yes, Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What treatment have you had for your pain?

* Surgery Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other Procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medications have been prescribed?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently restricted by a Pain Management Contract? \_\_ Y \_\_ N

* If yes, will Medical Marijuana violate the contract? \_\_Y \_\_N

**Patients with Other Chronic or Debilitating Conditions**

**Cachexia/Wasting Syndrome:**

* Original or Normal Weight:\_\_\_\_\_\_\_\_\_\_\_
* Weight Loss: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Time Period:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(i.e., 25 pounds in 3 months)

**Severe Nausea:**

* Frequency of Nausea: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Results of Nausea: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Cause of Nausea:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Seizures:**

* Initial seizure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Most recent seizure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Seizures in the past year:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Muscle Spasms:**

* Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Patients with Other Conditions**

HIV/AIDS: Date of Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Most recent CD4 Count: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALS: Date of Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer: Date of Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Type/Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Treatments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Crohn’s Disease: Date of Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_

Glaucoma: Date of Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis C: Date of Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PTSD: Date of Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Current treatment \_\_ Yes \_\_No
* Name of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_