Arkansas Progressive Medicine

New Patient Intake Form

Please fill out this form completely

Name:____ ______________________

Date of Birth:_________________________ Age:__________ Sex: M or F *(circle one)* Race:__________________

Address:_____________________________________ City:________________________ State:_______ Zip:_________

Home Phone:________________________ Cell:__________________________ Email:___________________________

AR Driver's License #:_____________________________ or State ID Card #:___________________________________

How did you hear about us?:____

Your Medical Information

Health Habits: How much Alcohol do you consume each week?____________________Tobacco?___________________

If you are female, is thereany possibility you could be pregnant? Yes or No*(circle one)*

Is there a family history of any medical problems? If yes, please explain:_______________________________________

Have you had any surgeries or broken bones? If yes, please explain:____

____

Please list medications, both prescription and over- the- counter:____

____

Please listall allergies or side effects to medications:____*(side effects may be one reason to use medical marijuana instead of pills)*

Your Last Medical Doctor or Clinic Visit

Name:_______________________________________ Phone:____________________ Fax:_________________

Address, City, State, Zip:____

Date and Reason for the visit:____

Date and Reason for any planned visits:____

If there is no visit in the past 10 years, please state why:____

(If you DO NOT Remember your last doctor's visit, please write I DO NOT REMEMBER across this section)

Medical Symptoms/Diagnosis or Reason for Today's Evaluation

I,____, am here to see the doctor today because I request an evaluation for a medical marijuana recommendation. I believe that the medicinal use of marijuana will relieve my symptoms. I have the following symptoms and/or diagnoses:

(Circle all that apply below:)

	Symptoms		Symptoms
	Anxiety / Stress / Insomnia/Rage		Nausea/ Vomiting /Abdominal Pain/ Chronic Stomach Upset
	Depressed feelings/Suicidal (Now)?		Difficulty Gaining Weight / Lack of Appetite
	Headaches		Chronic Cough
	Back Pain/Upper Mid Lower		Chest Pain (now)?/Shortness of Breath
	Neck Pain / TMJ Dysfunction		Skin Irritation
	Joint Pain:_______________		Dizziness / Vision problems / Vertigo
	Muscle spasms:_____________		Urinary problems
	Numbness or tingling in limbs		Erectile Dysfunction / Libido
	Menstrual Cramps / Hot Flashes		History of Addiction to:
	Diagnosis by your Doctor		**Diagnosis by your Doctor**
	AIDS / HIV/Wasting Syndrome		Asthma / COPD / Pulmonary Fibrosis
	ADD / ADHD (attention hyperactivity disorder)		Arthritis: Rheumatoid / Osteoarthritis / Psoriatic / Gout
	Bipolar/Depression / OCD		Cancer of:_____________________________________
	Anxiety/Panic disorder		Diabetes: Controlled / Uncontrolled HgbA1c?___________
	Schizophrenia / Schizoaffective Disorder		Restless Leg Syndrome
	PTSD (post traumatic stress disorder)		Epilepsy / Seizures / Traumatic Brain Injury / Stroke
	Heart Disease/High Blood Pressure/A-Fib		Hepatitis: B C (Circle one)/ Cirrhosis
	Alzheimer's/Dementia		Kidney Disease/Chronic Interstitial Cystitis /Polycystic Kidney
	Migraine /Tension Headaches		Multiple Sclerosis / Cerebral Palsy / Parkinson's / ALS
	Stomach Ulcers/Ulcerative Colitis / GERD		Fibromyalgia / Lupus / Lyme Disease /Auto Immune Disorder
	Crohn's Disease/IBS/Cyclic Vomiting		Psoriasis / Eczema / Other:_________________
	Menopause/ Polycystic Ovarian Syndrome		Neuropathy of:____
	Thyroid Disease / Hashimoto's		Glaucoma/Intraocular Pressure/Macular Degeneration

Each Box Marked Above will be discussed at length with Dr. Flippin. <u>It takes only ONE to qualify</u>.

For what symptoms are you seeking medical marijuana:

<u>(It is very important that every line is complete)</u>

1. What medical issue will you be seeing the doctor for today____
2. What caused your problem:____
3. How long have you had these symptoms:____
4. Intensity/Frequency of Symptoms:____
5. What treatments have you tried for this issue:____

Do you wish to be reminded of your renewal ? Y/N
Email:____

Complete the entire form, sign, initial and date where applicable.

Patient Statement Regarding Primary Diagnosis and Medical Records

Have you seen a doctor or been to a clinic for your medical symptoms / problems?
Please circle **Yes** or **No** here

1. If you answered YES, then please provide us with a copy of your medical records, x-rays, and prescriptions from your treating physician / clinic *(the doctor you listed on Page 1)*
2. If you answered YES but CANNOT provide the medical record copies, then please provide the following information:

I cannot provide the records because:____

Your personal statement regarding the above facts:

I, (print your name)____, confirm that the information provided by me regarding my diagnosis and medical records is true and correct.

X____
Patient's Signature Date

Disclosures and Conditions

- Based on my beliefs and awareness of researched scientific evidence of the benefits of medical cannabis, I request that the doctor evaluate me for a recommendation to use medical cannabis. This would enable me to legally obtain medical marijuana to use for treatment of my medical conditions.
- If medical cannabis adversely affects my health, I will stop using medical cannabis. I assume all risk for the use of medical cannabis.
- I agree to obtain medical follow-up at my personal medical doctor's office, or obtain a personal doctor I have none now and to return this office for follow-up as recommended by the physician. I understand this is an obligation on my part for the continuity of care.
- I agree NOT TO DRIVE or operate heavy equipment while using medical cannabis.
- I DO NOT plan or intend to use my physician's recommendations for the purpose of illegally obtaining medical cannabis.
- I understand that I MUST be a Arkansas resident to obtain an approval or recommendation for the use of medical cannabis under Arkansas law. I affirm that I have a serious medical condition that adversely affects my quality of life.
- I have been assured that medical records relating to my care will be kept private and confidential and that no information will be released or printed, which would disclose my personal identity, unless required by law.
- It should be made absolutely clear that the physician, staff or representatives of this center are neither providing medical cannabis, nor are they encouraging any illegal activity in my obtaining or using medical cannabis.
- Furthermore, the undersigned, my heirs, assignees, or anyone acting on my behalf, hold the physician, the staff or any agents of this center free and harmless of any liability resulting from the use of medical cannabis.

I have read, understood and affirm all of the above statements.

X____ Date:_________________________

Arkansas Progressive Medicine
1000 East Matthews, Suite E
Jonesboro, AR 72401
(870) 520-6007

HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in the treatment directly or indirectly.
- Obtain payment from designated third-party payers
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent and acknowledge that I have studied the Privacy Practices prior to signing this consent and acknowledge that I have studied the Privacy practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on the consent.

______________________________	______________________________
Patient's Name	DOB: (mm/dd/yy)
______________________________	______________________________
Signed (Patient or Legal Rep for the Patient)	Date:

____
Legal Representative's Relationship to Patient