Therapeutic Health Clinic
1417 NW 150th St. Edmond. OK 73013. T: (405) 285-0471. F: (321) 204-7063

Patient Name: ..... Date of Birth:.....

NEW PATIENT QUESTIONNAIRE

We would like to welcome you to our clinic. Thank you for selecting our team. We are committed to provide you with the best possible health care.

To help us assess your current health care needs, we would like you to complete the following forms. We know that we are asking you many questions, but we feel that it is important that you take the time to complete all pages. Many of our patients have seen several other health care providers, and continue to experience ongoing (medical) problems. Our comprehensive questionnaires really help us to determine the best diagnosis and treatment plan.

If you have any questions or need assistance, please feel free to ask us. We will be happy to help.

IMPORTANT: All pages must be completed and returned to our office prior to your scheduled appointment. If you have any questions regarding these forms, please contact us prior to your appointment so we may assist you. Incomplete forms may delay medical cannabis treatments.

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Patient Name: ..... Date of Birth:.....

Name_____ Date_____
DOB_____
Address_____
County_____
SSN _____
Phone #_____
Email address_____

Gender: Male [ ]. Female [ ]. If female, Are you pregnant? [ ]no [ ] yes [ ] not sure

Primary Care Physician and phone number_____

Allergies:. ☐ No. ☐ Yes: .....

Please list the **previous surgeries** with **dates:**

☐
☐
☐

Family Past Medical History

☐ Father

☐ Mother

☐ **Others:**

Patient social history

Smoker: ☐ No ☐ Yes: ..... packs/day X_____ year

Alcohol: ☐ No ☐ Yes: Occasional (last drink____). Daily (How much and what:_____

Drug Use: ☐ No ☐ Yes: Current/Previous (☐ Marijuana ☐ Cocaine ☐ Methamphetamines ☐ Other

Have you ever had a problem with dependency or abuse of prescription or nonprescription drugs? ☐ No

☐ Yes : .....

Have you been convicted with a felony in the past two years that involve any illicit substance? ☐ No

☐ Yes : .....

Current Medications:

- - -

Patient Name: ..... Date of Birth:.....

Past Medical History and reasons for cannabis treatment (circle all that applies)

- ADHA
- Alzheimer's disease
- Amputation/ loss of limbs
- Amyotrophic lateral sclerosis
- Anorexia and other eating disorders
- Anxiety/ Panic/Stress
- Arthritis/ Rheumatoid? / Osteoarthritis? Which joint:
- Cachexia/ Wasting syndrome
- Cancer
- Central pain syndrome
- Chronic severe pain
- Complex regional pain syndrome/ RSD
- Crohn's disease
- Depression/ Bipolar
- Fibromyalgia
- Glaucoma
- Headaches/ Migraines
- Hepatitis C
- HIV/AIDS
- Insomnia
- Multiple sclerosis
- Paraplegia
- Parkinson Disease
- Peripheral neuropathy
- Persistent Muscle spasms
- Phantom pain
- Post-traumatic stress disorder (PTSD)
- Quadriplegia
- Seizures
- Severe nausea
- Spinal disease / Stenosis/ Degenerative/ Neck, middle back, low back
- Strokes
- Surgical scars/ neuromas
- Terminal illness
- Tourette's syndrome
- Tremors
- Ulcerative colitis
- Other debilitating illness (explain)_____
-

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From the list above. Chose three problems and provide more details:

Condition #1:	
When Started?	▪ started ___ years ago, ▪ Since birth/ childhood , ▪ After an accident/ injury ▪ Other:
Progress:	▪ constant ▪ varying intensity with frequent flare ups, ▪ intermittent with few flare ups ▪ Other: ▪
Severity:	▪ improving , ▪ W orsening , ▪ mild , ▪ moderate , ▪ severe , ▪ Other: ▪
Associated Symptoms:	▪ seizures and/or abnormal movements , bladder or urinary tract dysfunction , bowel dysfunction , concentration difficulties , dizziness or balance disturbances , fever , inflammatory symptoms , malaise , nausea , vomiting , numbness , tingling , weakness , paralysis
Previous Tests:	CT scan/ X-Rays , MRA / MRI EEG , EMG /nerve conduction, lumbar puncture , Other:
Previous Treatment:	▪ None , ▪ Marijuana, ▪ OTC medications , prescription medication , assistive devices chiropractic /Physical therapy , massage therapy / occupational therapy , Injections/ Procedures , psychotherapy, herbal therapy , acupuncture , surgery, ▪ Other: ▪
Effect on daily living activities	▪ none , problems at home , problems at work/school , unable to go to work/school , interpersonal problems , Sleep disturbances ▪ Other: ▪

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Condition #2:	
When Started?	▪ started ___ years ago, ▪ Since birth/ childhood , ▪ After an accident/ injury ▪ Other:
Progress:	▪ constant ▪ varying intensity with frequent flare ups, ▪ intermittent with few flare ups ▪ Other: ▪
Severity:	▪ improving , ▪ W orsening , ▪ mild , ▪ moderate , ▪ severe , ▪ Other: ▪
Associated Symptoms:	▪ seizures and/or abnormal movements , bladder or urinary tract dysfunction , bowel dysfunction , concentration difficulties , dizziness or balance disturbances , fever , inflammatory symptoms , malaise , nausea , vomiting , numbness , tingling , weakness , paralysis
Previous Tests:	CT scan/ X-Rays , MRA / MRI EEG , EMG /nerve conduction, lumbar puncture , Other:
Previous Treatment:	▪ None , ▪ Marijuana, ▪ OTC medications , prescription medication , assistive devices chiropractic /Physical therapy , massage therapy / occupational therapy , Injections/ Procedures , psychotherapy, herbal therapy , acupuncture , surgery, ▪ Other: ▪
Effect on daily living activities	▪ none , problems at home , problems at work/school , unable to go to work/school , interpersonal problems , Sleep disturbances ▪ Other: ▪

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Condition #3:	
When Started?	▪ started ___ years ago, ▪ Since birth/ childhood , ▪ After an accident/ injury ▪ Other:
Progress:	▪ constant ▪ varying intensity with frequent flare ups, ▪ intermittent with few flare ups ▪ Other: ▪
Severity:	▪ improving , ▪ W orsening , ▪ mild , ▪ moderate , ▪ severe , ▪ Other: ▪
Associated Symptoms:	▪ seizures and/or abnormal movements , bladder or urinary tract dysfunction , bowel dysfunction , concentration difficulties , dizziness or balance disturbances , fever , inflammatory symptoms , malaise , nausea , vomiting , numbness , tingling , weakness , paralysis
Previous Tests:	CT scan/ X-Rays , MRA / MRI EEG , EMG /nerve conduction, lumbar puncture , Other:
Previous Treatment:	▪ None , ▪ Marijuana, ▪ OTC medications , prescription medication , assistive devices chiropractic /Physical therapy , massage therapy / occupational therapy , Injections/ Procedures , psychotherapy, herbal therapy , acupuncture , surgery, ▪ Other: ▪
Effect on daily living activities	▪ none , problems at home , problems at work/school , unable to go to work/school , interpersonal problems , Sleep disturbances ▪ Other: ▪