LEAF RN Client Intake Form

*Name: ______________________ Today's date: ______________________
*Address: ______________________ Cell Phone : ______________________
______________________ Home phone: ______________________
Current Age: ________
Emergency Contact Name: ______________________ Relationship: __________
Emergency Contact Phone: ______________________

*Reason for Visit: ______________________

***Describe your experience with Cannabis or CBD products. Include how you have ingested it** *(Edibles, Tinctures/drops, Topicals, Suppositories, Smoked, or Vaped):*

***What methods of indgestion would you be open to trying?**

Please Complete the next sections to the best of your ability

Allergies:	Medications or Food:	Reaction:

Past Medical History

Nervous system:

Condition	☐	Condition	☐
Migraines		Stress Headaches	
Anxiety		Depression	
Bi-polar		Addiction	
PTSD		Stroke	
Nerve injury		Paralysis	
Neuropathy		Parkinsons	
Alzheimers		Sezures	

Other conditions: ______________________

Circulatory system:

Condition	☐	Condition	☐
Heart attack		High Blood pressure	
High cholesterol		Blood Clots	
Stents		Heart surgery	
Heart valve problems		Vein or artery surgery	

Other conditions: ______________________

Respiratory:	Asthma	[ ]	Bronchitis	[ ]
	COPD	[ ]	Emphysema	[ ]
	Blood clots	[ ]	Reactive Airway	[ ]
	Other conditions:	________		

Muscles and skeletal:	Osteoarthritis	[ ]	Rheumatoid arthritis	[ ]
	Osteoporosis	[ ]	Joint injury	[ ]
	Joint replacement	[ ]	Fibromyalgia	[ ]
	Muscle spasms	[ ]	Back injury	[ ]
	Other Conditions:	________		

GI:	Constipation	[ ]	Diarrhea	[ ]
	IBS	[ ]	Chrohns	[ ]
	GERD/Acid reflux	[ ]	Chronic nausea	[ ]
	Hyperemesis/chronic vomitting	[ ]	Permanent feeding tube	[ ]
	Esphagelia Verocities	[ ]	Colostomy	[ ]
	Ulcerative Colitis	[ ]	Diverticulitis	[ ]
	Hepatitis	[ ]	Type of Hepatitis	________
	Liver disease	[ ]	Type of disease	________
	Other Conditions	________		

Urological:	Stress incontinence	[ ]	Cystitis	[ ]
	Bladder retention	[ ]	Frequency	[ ]
	Frequent UTI's	[ ]	Bladder stones	[ ]
	Kidney stones	[ ]	Kidney Insufficiency	[ ]
	Kidney Failure	[ ]	Dialysis	[ ]
	Stents	[ ]		
	Other Condtions	________		

Skin:	Rash	[ ]	Open sores	[ ]
	Other Conditions	________		

Endocrine:	Diabetes	[ ]	Type: **I** **II**	Use Insulin: **YES** **NO**	
	Hypothyroidims	[ ]		BPH	[ ]
	Adrenal Insufficency	[ ]		Endometriosis	[ ]
	Hormone Therapy	[ ]		Type of Therapy:	________
	Other Conditions	________			