



IDENTIFYING DATA:

Last name: _____ First name: _____ MI: _____

Birth date: _____ Age _____ Gender: Male Female

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Email: _____

How did you hear about us: _____

Who can we thank for referring you _____

Race: African Asian Hispanic Caucasian Native American Others _____

Occupation(s): _____

Current employment: Full Time Part Time Unemployed Retired Disabled

Emergency contact: *(Name, Relationship, Phone)* _____

GENERAL INFORMATION:

Primary care physician or clinic, Name: _____ Phone: _____

Address _____ City _____ Zip _____

Specialist / Consultant, Name and Location: _____

MEDICAL HISTORY

Chief Complaint(s):

What is the main problem for which you seek evaluation and treatment today (or the main reason you currently use cannabis) i.e. nausea, anorexia, spasms, pain, etc.? _____

When did this problem start?

< 1 month < 1 year 1 – 3 years 3 – 5 years 5 – 10 years > 10 years

When did you last see your doctor or a specialist about this complaint?

< 1 month < 1 year 1 – 3 years 3 – 5 years 5 – 10 years > 10 years

Check treatment modalities that you have tried in treating your problem:

- Medications Surgery Therapeutic injections Physical therapy Osteopathic Care
- Chiropractic Care Acupuncture Counseling Others: _____

Current Prescription Medications: *List names, dosage, frequency of use, and how long taken*

1. _____ Dosage _____ Frequency _____ Duration _____
2. _____ Dosage _____ Frequency _____ Duration _____
3. _____ Dosage _____ Frequency _____ Duration _____

Previous Prescription Medications: *(relevant) names, duration, and reasons of stopping.*

1. _____
2. _____
3. _____

Over-the-Counter and Herbal Medications: *List products that you use or have used in the past for the condition for which cannabis is used (intended), i.e. ibuprofen, aspirin, glucosamine, milk thistle.*

PAST MEDICAL HISTORY

✓ check the box most applicable to you

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Arthritis <input type="checkbox"/> Back and neck pain <input type="checkbox"/> Blood Disorders (anemia, abnormal clotting) <input type="checkbox"/> Brain disorders (epilepsy, trauma, etc) <input type="checkbox"/> Breast lesions <input type="checkbox"/> Cancer, specify: <input type="checkbox"/> Chronic pain, specify: <input type="checkbox"/> Circulation (stroke, phlebitis, etc) <input type="checkbox"/> Diabetes <input type="checkbox"/> Dystonia (spasms, tremors, Parkinson's) <input type="checkbox"/> Ear problems (tinnitus, hearing loss) <input type="checkbox"/> Eating disorder (anorexia, bulimia) <input type="checkbox"/> Endocrine problems (thyroid, hormones) <input type="checkbox"/> Eye problems (glaucoma, cataracts) <input type="checkbox"/> Genital / GYN problems <input type="checkbox"/> Heart disease | <ul style="list-style-type: none"> <input type="checkbox"/> Herpes zoster / shingles / other <input type="checkbox"/> High blood pressure <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Intestinal disorders (ulcers, colitis, IBS) <input type="checkbox"/> Kidney disease (cystitis, renal failure) <input type="checkbox"/> Liver disease (cirrhosis, hepatitis B or C) <input type="checkbox"/> Lungs disease (asthma, emphysema) <input type="checkbox"/> Mental disorders (depression, anxiety, PTSD) <input type="checkbox"/> Migraine headache <input type="checkbox"/> Multiple sclerosis (neurodegenerative disease) <input type="checkbox"/> Prostate disease <input type="checkbox"/> Rheumatic disease (Lupus, Sjogrens, Reiters) <input type="checkbox"/> Skin disorders (psoriasis, eczema) <input type="checkbox"/> Sleep disorders (insomnia, sleep apnea) <input type="checkbox"/> Substance abuse (tobacco, alcohol, other drugs) <input type="checkbox"/> Weight loss / gain |
|---|---|

PAST SURGICAL HISTORY: *Please list in chronological order surgeries and approximate dates.*

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Medical Marijuana Acknowledgement of Disclosure and informed consent

Read each item below and initial in the space provided to indicate that you understand and agree to each item. Do not sign this agreement and do not use medical marijuana if you have questions about or don't understand the information you have received.

I, _____ (patient's full name), Understand that medical marijuana is a medicine use=d treating the suffering caused by serious and debilitating medical conditions. Serious medical conditions include (but are not limited to):Anorexia, Arthritis, Cachexia, Cancer, Glaucoma, HIV, Migraines, Muscle Spasm, Seizures, Chronic Pain, and Severe Nausea. Additionally, medical marijuana is used in the treatment of other chronic or persistent medical symptoms that: Substantially limit the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336) If not alleviated may cause serious harm to the patient's health. I understand California's Compassionate Use Act of 1996, (Health & Safety Code #11362.5), provides for the possession and cultivation of cannabis (medical marijuana) for the personal medical purposes of the patient with a physician approval or recommendation. It should be made absolutely clear that the physician, staff and representatives of this practice are neither providing cannabis, nor are they encouraging any illegal activity in my obtaining cannabis (medical marijuana).

Initials _____

Although smoking marijuana has not been linked to lung cancer, smoking can cause respiratory harm such as bronchitis. I am advised that the cannabis (medical marijuana) smoke contains chemicals known as tars that may be harmful to my health. Recent research indicates that vaporizing cannabis may eliminate exposure to tar. Should respiratory problems or other ill effects be experienced in association with its use, it should be discontinued and reported to the physician.

Initials _____

I understand the side effects may occur while I am consuming medical marijuana. These side effects have been explained to me. Side effects of marijuana can include, but are not limit to euphoria; sedation; dizziness; anxiety; confusion; fatigue; inability to concentrate; difficulty in completing complex tasks; impairment of motor skills; impaired perception; diminished short-term memory; Dry mouth; slowness; loss of concentration and coordination; impaired judgment; increase risk of accidents; loss of motivation; diminished inhibitions; increased heart rate, anxiety, panic attacks, and paranoia; hallucinations; damage to the respiratory, reproductive, and immune systems; increase risk of cancer; and psychological dependency; psychotic symptoms.

Initials _____

For some patients, chronic marijuana overdose can lead to laryngitis, bronchitis, or general apathy. Marijuana varies in potency. The effects of marijuana can also vary with the delivery method. Estimating the proper marijuana dosage is very important. Systems of a marijuana overdose include nausea, numbness of the limbs, hacking cough and vomiting. I understand that using marijuana while under the influence of alcohol is not recommended.

Initials _____

Using marijuana may decrease reproductive functions in men as well as woman. Woman, who are trying to conceive, or are pregnant or breast feeding should not use marijuana. This means they experience withdrawal symptoms when they stop using marijuana. Signs of withdraw, while generally mild can include feeling depressed, sadness, irritability, restlessness, or mild agitation, insomnia, sleep disturbances, unusual tiredness, trouble concentrating, loss of appetite.

Initials _____

Although marijuana does not produce a specific psychosis, the possibility exist that it may exacerbate schizophrenia in persons predisposed to that disorder

Initials _____

I have been assured that records relating to my care will be kept confidential and that no information will be released or printed that would disclose personal identity, unless required by law, or for verifications on your behalf.

Initials _____

I understand that the attending physician does not suggest nor condone that I cease treatment of medications that stabilize my mental or physical condition. I affirm that I have a serious medical condition that adversely affects my quality of life. I have found or an interested in finding weather cannabis provides relief and improvement for my condition. If I start taking medical marijuana, I agree to inform my physician if I start to feel sad, lose my appetite, become unusually tired, lose interest in activities, have change in my sleeping patterns, become more irritable than usual, or have withdraw from family and friends.

Initials _____

I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities and/or contaminants. I understand the potential risks associated with an elevated daily consumption of marijuana including risks with respect to the effect on my cardiovascular and pulmonary systems and psychomotor performance, risks associated with the long-term use of marijuana, as well as potential drug dependency. I am aware that the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. In requesting an approval or recommendation for the use of this plant as medication, I assume full responsibility for any and all risks of this action.

Initials _____

I understand that the use of cannabis may affect my coordination and cognition in ways that could impair my ability to drive, operate heavy machinery, or engage in potentially hazardous activities. I assume full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis.

I understand some users develop a tolerance to marijuana, this means higher doses are required to achieve the same pain relief. If I think I may be developing a tolerance to marijuana, I will notify my attending physician. I will notify my attending physician

Initials _____

I will notify my attending physician should repertory problems or other ill effects be experienced in association with the use of medical marijuana, I agree to discontinue its use and report such problems to the attending physician. I understand that the attending physician, staff, management, and representatives who associate with the physicians practice, are neither providing nor dispensing cannabis, nor are they encouraging any illegal activity in obtaining medical marijuana. At this time, Cannabis is an alternative or complementary treatment. I understand to receive a recommendation to use cannabis legally in California I should have tried, or be willing to consider trying, at least one other recommendation treatment from a medical provider. I have obtained or attempted to obtain medical records pertaining to my condition or currently have no medical records pertaining to my condition and agree to be referred for further evaluation as the physician deems necessary.

Initials _____

Release of Liability

I, THE UNDERSIGNED, HERBY REQUEST A CONSULTATION BY A PHYSICIAN FOR THE PURPOSES OF DETERMINING THE APPROPRIATENESS OF MEDICAL CANNABIS TREATMENT. THERE ARE NO CLAIMS ABOUT THE MEDICAL EFFICACYS OF CANNABIS. The physician, staff, representatives, and the attending physician of the holistic clinic are addressing specific aspects of my medical care, and unless otherwise started are in no way establishing themselves as my primary care provider. The physician is only rendering an opinion regarding the therapeutic value of the use of medical marijuana. Should an approval be made for my medical use of cannabis, I understand that there is a renewal date specified by the physician. Furthermore, the undersigned my heirs, assigns, or anyone acting on my behalf, hold the physician, staff, and representatives, free of and harmless from any responsibility and liability resulting from the use of cannabis. I certify and declare under penalty of perjury that I have read and understood the information contained herein, and the information I have given is true and complete.

PATIENTS FULL NAME (print) _____ PATIENTS SIGNATURE _____ DATE _____