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PATIENT INTAKE FORM

TODAY'S DATE: 07/07/2021 REFERRED BY:_____

PATIENT NAME:_____

D.O.B._____LAST FOUR OF SS#:***-**-_____

SEX: MALE FEMALE MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOW

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____CELL PHONE:_____

WORK PHONE:_____EMAIL:_____

(PLEASE CIRCLE PREFERRED CONTACT NUMBER AND **AM** OR **PM**)

PLACE OF EMPLOYMENT:_____

JOB TITLE:_____

HIGHEST DEGREE ATTAINED:_____

MILITARY EXPERIENCE: Y N COMBAT: Y N BRANCH:_____RANK:_____

ARE YOU CURRENTLY ON PROBATION OR PAROLE? Y N EXPLAIN:_____

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PRIMARY CARE PRACTITIONER:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PHONE:_____FAX:_____

THERAPIST CONTACT INFORMATION:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PHONE:_____FAX:_____

HAVE YOU DISCUSSED MEDICAL MARIJUANA WITH YOUR PCP OR THERAPIST? YES NO

HOW DID THEY RESPOND?_____

PLEASE LIST ANY ALLERGIES:_____

_____

PLEASE LIST CURRENT MEDICATIONS WITH DOSING:_____

_____

_____

_____

_____

PLEASE LIST PAST SURGERIES AND DATES: (APPROXIMATE)

_____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY:(PLEASE CHECK IF YOU HAVE BEEN DIAGNOSED WITH ANY OF THE BELOW)

- ❑ CHRONIC HYPERTENSION
- ❑ HEART DISEASE/CHF
- ❑ HEART ATTACK/MI
- ❑ CVA/TIA/STROKE
- ❑ PULMONARY DYSFUNCTION
- ❑ ASTHMA/COPD
- ❑ THYROID DISORDER
- ❑ DIABETES
- ❑ OBESITY
- ❑ BLEEDING OR CLOTTING DISORDER
- ❑ GOUT
- ❑ KIDNEY DISEASE
- ❑ MIGRAINE HEADACHES
- ❑ SKIN DISEASE
- ❑ INSOMNIA
- ❑ ANXIETY
- ❑ MENTAL ILLNESS
- ❑ ALCOHOLISM
- ❑ **HIV**
- ❑ **AIDS**
- ❑ **AMYOTROPHIC LATERAL SCLEROSIS (ALS)**
- ❑ **CANCER**
- ❑ **CHRONIC TRAUMATIC ENCEPHALOPATHY (CTE)**

- ❑ **EPILEPSY OR ANOTHER SEIZURE DISORDER**
- ❑ **FIBROMYALGIA**
- ❑ **GLAUCOMA**
- ❑ **HEPATITIS C**
- ❑ **MULTIPLE SCLEROSIS**
- ❑ **PAIN THAT IS CHRONIC AND SEVERE OR INTRACTABLE**
- ❑ **PARKINSON'S DISEASE**
- ❑ **POST-TRAUMATIC STRESS DISORDER**
- ❑ **SICKLE CELL ANEMIA**
- ❑ **SPINAL CORD DISEASE OR INJURY**
- ❑ **TOURETTE'S SYNDROME**
- ❑ **TRAUMATIC BRAIN INJURY (TBI)**
- ❑ **INFLAMMATORY BOWEL DISEASE**
    - ❑ **CROHN'S DISEASE**
    - ❑ **ULCERATIVE COLITIS**

FAMILY MEDICAL HISTORY:

- ❑ CHRONIC HYPERTENSION
- ❑ HEART DISEASE/CHF
- ❑ HEART ATTACK/MI
- ❑ CVA/TIA/STROKE
- ❑ PULMONARY DYSFUNCTION
- ❑ ASTHMA/COPD
- ❑ THYROID DISORDER
- ❑ DIABETES
- ❑ OBESITY
- ❑ BLEEDING OR CLOTTING DISORDER
- ❑ GOUT
- ❑ KIDNEY DISEASE
- ❑ MENTAL ILLNESS
- ❑ ALCOHOLISM
- ❑ **HIV**
- ❑ **AIDS**
- ❑ **AMYOTROPHIC LATERAL SCLEROSIS (ALS)**
- ❑ **CANCER**
- ❑ **CHRONIC TRAUMATIC ENCEPHALOPATHY (CTE)**
- ❑ **EPILEPSY OR ANOTHER SEIZURE DISORDER**
- ❑ **FIBROMYALGIA**
- ❑ **GLAUCOMA**
- ❑ **HEPATITIS C**
- ❑ **MULTIPLE SCLEROSIS**

- ❑ **PAIN THAT IS CHRONIC AND SEVERE OR INTRACTABLE**
- ❑ **PARKINSON'S DISEASE**
- ❑ **POST-TRAUMATIC STRESS DISORDER**
- ❑ **SICKLE CELL ANEMIA**
- ❑ **SPINAL CORD DISEASE OR INJURY**
- ❑ **TOURETTE'S SYNDROME**
- ❑ **TRAUMATIC BRAIN INJURY (TBI)**
- ❑ **INFLAMMATORY BOWEL DISEASE**
    - ❑ **CROHN'S DISEASE**
    - ❑ **ULCERATIVE COLITIS**

PAIN HISTORY

Mankoski Pain Scale: my pain ...

- ❑ 0...is non-existent
- ❑ 1...is a very minor annoyance
- ❑ 2...is a minor annoyance
- ❑ 3...is annoying enough to be distracting and requires very minor painkillers
- ❑ 4...is distracting; mild painkillers alleviate pain for 3-4 hours
- ❑ 5...can't be ignored for more than 30 minutes and requires mild painkillers
- ❑ 6...can't be ignored at all and requires strong painkillers
- ❑ 7...creates difficulty concentrating and sleeping; strong painkillers don't work
- ❑ 8...is severe during physical activity, and creates nausea and dizziness
- ❑ 9...makes me cry and moan, unable to speak, and near delirium
- ❑ 10...knocks me unconscious

Nature of pain is: (circle all that apply)

acute sharp radiating burning

chronic (6 months or more) associated with numbness

Location of pain:_____

Underlying diagnosis:_____

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PLEASE LIST THE CURRENT CONDITION(S) YOU HOPE TO MEDICATE WITH CANNABIS:

_____

_____

CANNABIS USE HISTORY:

- ❑ I DO NOT CURRENTLY USE CANNABIS (SKIP TO *SOCIAL HABITS* SECTION)
- ❑ USE SOCIALLY
- ❑ USE OCCASIONALLY

AGE OF FIRST USE:_____

PREFERRED CANNABIS TYPE:_____

PREFERRED INTAKE METHOD:_____

FREQUENCY OF CANNABIS USE:_____

AMOUNT USED (GRAMS/WEEK):_____

HAVE YOU EVER USED MARINOL (THC IN PILL FORM)? YES NO

WHY AND RESULTS?_____

HOW & WHEN DID YOU DISCOVER THAT CANNABIS HELPED YOUR SYMPTOMS?

_____

SOCIAL HABITS: (PLEASE CHECK ALL THAT APPLY)

- ❏ ROUTINE EXERCISE:_____X PER DAY / WEEK / MONTH
- ❏ CAFFEINE:_____DRINKS PER DAY / WEEK/ MONTH
- ❏ ALCOHOL:_____DRINKS PER DAY / WEEK / MONTH
- ❏ TOBACCO:_____ PER DAY / WEEK / MONTH
- ❏ COCAINE:_____X PER DAY / WEEK / MONTH
- ❏ HEROIN:_____X PER DAY / WEEK / MONTH
- ❏ LSD/ECSTASY/PSILOCYBIN:_____X PER DAY / WEEK / MONTH
- ❏ OTHER:_____X PER DAY / WEEK / MONTH
- ❏ PLEASE GIVE ME INFORMATION ABOUT HELP WITH STOPPING ONE OR MORE OF THE ABOVE HABITS THAT MAY BE DETRIMENTAL TO MY HEALTH.

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*****OFFICE POLICIES AGREEMENT*****

By signing below, you acknowledge that you have read, understand, and agree to the following policies:

1. **An annual appointment is required to renew medical marijuana recommendation letters by state law.**
2. **Cost for office appointment for initial evaluation and assessment for medical marijuana is $250.**
3. **24 hour notice is required for cancellations. There is a $50 fee for no-shows.**
4. **A written recommendation for medical marijuana cannot exceed 90 days.**
5. **Ohio mandates a OARRS query be done on all patients.**
6. **Parental consent must be obtained for all recommendations to minors.**
7. **Prescription refill requests must be called at least 72 hours in advance and may require an appointment.**

_____ _____

Patient Signature *Date*