INITIAL/RETURNING VISIT FORM

Name:
Date of Birth:
Age:
Gender:

Address:
City:
Zip:
Cell Phone Number:
E-mail Address:

Driver's License Number:
Expiration Date of Driver's License:

DOCTOR'S INFO
(note that in order to protect your privacy, your doctor will not be contacted without your explicit written consent)

Who is your current doctor?
Name:

Where is your current doctor located?
City:
State:

When was your last visit to your doctor?

Have you talk to your doctor about medical marijuana? If not, then please explain why.

MEDICAL HISTORY

Are you currently pregnant?

Are you currently breastfeeding?

What medical conditions have you been diagnosed with? Please provide dates of diagnosis.

What surgeries have you had? Please provide dates of surgeries.

Do you have a family history of schizophrenia, bipolar disorder, or psychosis?

Which medical conditions are you looking to treat with medical marijuana?

How are these medical conditions interfering with your life?

Why did you decide to turn to medical marijuana as a treatment option?

What are you hoping to get out of the consultation today?

Prescription Medications (if you brought a list with you, then skip over this section)

NAME OF MEDICATION	Are you taking this medication currently?	What side effects, if any, are you experiencing from this medication?	How long have you been taking this medication for?

What Over–the-Counter and Alternative medications do you use?

What alternative treatments have you sought in the past?

Chiropractics	Vitamins	Massage	Meditation
Yoga	Exercise	Physical Therapy	Other:
Acupuncture	Counseling		

MARIJUANA RELATED HISTORY

What are your concerns, if any, about using medical marijuana?

Have you had a medical marijuana card before?

Have you used marijuana before?

How has marijuana helped you?

Which method(s) of administration have you used?

- ☐ Inhale: Smoke/Vaporize
- ☐ Ingest
- ☐ Topical
- ☐ Other:

What are the names of the medical marijuana products that you've used before?

What amount (dose) of these products did you use?

How many times a day did you take this amount (dose)?

How many times in a week did you use these products?

Have you experienced any adverse side effects from marijuana?

OTHER

How did you hear about this clinic?

Why did you select this clinic for an evaluation for a medical marijuana card?

I hereby declare, under penalty of perjury, that I have completely and truthfully disclosed all information regarding my medical condition. I am aware that my approval or recommendation may be revoked at any time if I have perjured or misrepresented myself or my condition.

I attest that I am not a member, employee or agent of any media or law enforcement agency. It is illegal for a patient to film or record in this office with video camera, cell phone or any other recording device whether still image, video or audio. This is a direct violation of HIPAA regulations and patient/doctor confidentiality.

_____ _____

Patient's Signature Date

_____ _____

Parent's/Legal Guardian's Signature (if applicable) Date