

Note All information is Confidential and is Protected by California and Federal Law

NAME: _____ DATE: _____
DATE OF BIRTH _____ AGE _____ HEIGHT _____ WEIGHT _____
Address _____ City _____ State _____ Zip _____

Email : _____ Phone# _____ Cell# _____

What is your occupation _____ Who do you live with _____

Do you have Medical Insurance? Yes / No Company _____

Do you have a primary care physician? Yes / No If Yes list below

Name _____

Please list any Specialist/ Consultants or Practitioners you have seen for your problems

Name /Info: _____ Name /Info: _____

Name /Info: _____ Name /Info: _____

What is the medical problem(s) you are seeking an evaluation for medical marijuana? (ex chronic pain)

When was the last time you saw a doctor about this problem? _____

What kinds of treatments have you tried for this problem? Circle all that apply

Medications, Herbs, Surgery, Spinal Injections, Physical Therapy, Osteopathic Care

Chiropractic Care, Acupuncture, Homeopathy, Counseling, Pain Management

Other _____

Have you ever been hospitalized? Yes No If Yes, give details and dates: _____

Have you ever had surgeries? Yes No If yes, give details and dates :

Are you currently under the care of a Pain Management Specialist Yes / No

Are you undergoing physical therapy Yes / No

Have you ever been diagnosed with Depression Yes / No

Have you ever been diagnosed with Schizophrenia Yes / No

Have you ever had any other Psychiatric Diagnosis Yes / No if yes explain: _____

Have you ever attempted Suicide Yes / No

Have you ever been Hospitalized for a Psychiatric problem Yes / No

Have you ever had issues with addiction Yes / No if yes explain: _____

How did you hear about us? _____

Patient Initials _____

Please list all medications and or herbs that you are taking currently_____

Allergies to Medications?_____

Do you currently smoke tobacco? Yes / No if yes, How much?_____

Do you currently drink alcohol? Yes ? No If yes How much?_____

*Are you currently using cannabis (marijuana) for your medical problems? Yes / No

If Yes, how many times? a day ___ a week ___ a month _____

If Yes, what method(s) do you use? ___ inhaled: ___ Vapor _____

ingested: ___ Tea _Capsule ___ Baked Goods ,Other _____

Why do you use cannabis over other medications?_____

Have you found cannabis to work better for your problem Yes / No if yes, why _____

Does cannabis allow you to function better Yes / No if yes, why _____

Does cannabis have any adverse side effects for you? Yes / No if yes, what _____

If you did not have a cannabis recommendation would you continue to use cannabis for your problems?

Yes / No

Have you discussed cannabis use for your problems with a doctor before? Yes / No

Are you currently having any of the following problems (Please circle):

Chest Pain

Diarrhea

Headaches

Shortness of Breath

Constipation

Change in vision

Cough

Stomach Pains

Change in hearing

Coughing of blood

Heartburn

Seizures

Palpitations

Changed Bowl Habits

Insomnia

Swollen Ankles

Weight loss/or gain

Anxiety

Blood in Stool

Vomiting

Other _____

Hallucinations

Suicidal thoughts

If you are female are you pregnant or planning pregnancy Yes / No N/A

Are there any problems that run in your family? Which family members are affected?_____

Do you have any current or prior legal or law enforcement problems involving controlled substances?

Yes / No If yes Explain:_____

Are you on probation? Yes / No _____

Please review your answers and be as complete as possible

Patient Signature _____