PATIENT INTAKE FORM

Name: ________________________________ ________________________________
Last Name First Name

Date of Birth: ______ /______ /______ Gender: ☐ Male ☐ Female

Address: ____

Town: ____________________________________ State: ________ Zip Code: __________

Home Phone: _____________________________ Cell: ____________________________

Email: ____

MMJ ID #:_______ **SCANNED IN** ____

Driver's License #:_______ **SCANNED IN** _______________________________________

Primary Care Physician:____

***MMJ Certifying Physician**: ____

Registered Caregiver (if applicable): ___________________ Phone #: _____________________
A Registered Caregiver is a person chosen by the patient to act as their agent in obtaining their medication at the dispensary. If you feel that you need a caregiver, please contact your certifying physician.

Are you a veteran? (Please check one) ☐ Yes ☐ No ***IF YES, PLEASE PROVIDE DOCUMENTATION***

Qualifying Condition:

Patients 18 years of age or older:

- ☐ Amyotrophic Lateral Sclerosis
- ☐ Cancer
- ☐ Cachexia
- ☐ Cerebral Palsy
- ☐ Complex Regional Pain Syndrome
- ☐ Crohn’s Disease
- ☐ Cystic Fibrosis
- ☐ Damage to the Nervous Tissue of the Spinal Cord with Objective Neurological Indication of Intractable Spasticity
- ☐ Epilepsy
- ☐ Fibromyalgia, spasticity/neuropathic pain associated with
- ☐ Glaucoma
- ☐ Hydrocephalus with Intractable Headache
- ☐ Intractable Headache Syndromes
- ☐ Irreversible Spinal Cord Injury with Objective Neurological Indication of Intractable Spasticity
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Neuropathic Facial Pain
- ☐ Osteogenesis Imperfecta
- ☐ Parkinson’s Disease
- ☐ Positive Status for Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome
- ☐ Post Herpetic Neuralgia
- ☐ Post Laminectomy Syndrome with Chronic Radiculopathy
- ☐ Post-Traumatic Stress Disorder
- ☐ Sickle Cell Disease
- ☐ Severe Psoriasis and Psoriatic Arthritis
- ☐ Severe Rheumatoid Arthritis
- ☐ Terminal Illness Requiring End-of-Life-Care
- ☐ Ulcerative Colitis
- ☐ Uncontrolled Intractable Seizure Disorder
- ☐ Wasting Syndrome

Qualifying Condition cont'd: for patients less than 18 years of age:

- ☐ Cerebral Palsy
- ☐ Cystic Fibrosis
- ☐ Irreversible Spinal Cord Injury with Objective Neurological Indication of Intractable Spasticity
- ☐ Muscular Dystrophy
- ☐ Osteogenesis Imperfecta
- ☐ Severe Epilepsy
- ☐ Terminal Illness Requiring End-of-Life Care
- ☐ Uncontrolled Intractable Seizure Disorder

Tobacco use? ☐ Yes ☐ No

Alcohol use? ☐ Yes ☐ No

Cannabis usage? ☐ Yes ☐ No

Please describe, if Applicable

Have you had any negative cannabis usage effects?

____

Have you had positive cannabis usage effects?

____

Negative symptoms that you are currently experiencing due to diagnosis: *(Please check all that apply)*

☐ Abdominal Pain / Cramping ☐ Anxiety ☐ Depression

☐ Difficulty Remaining / Falling Asleep ☐ General Pain ☐ Headaches

☐ Irritable or Hyperactive Bowels ☐ Muscle Pain / Stiffness ☐ Nausea / Vomiting

☐ Nerve Pain ☐ Ocular Pressure ☐ Opiate Dependence ☐ Poor Appetite

☐ Seizures ☐ Tremors ☐ Other ______________________________

Health Conditions: | **Allergies:**

Current Medication: | **Dosage:**

Provide List or write on back if additional space is needed

What outcomes do you hope to experience using medical cannabis?

What method of medical marijuana do you prefer? *(Please check all that apply)*

☐ Smoking ☐ Vaporizing ☐ Edibles ☐ Oils ☐ Tinctures ☐ Concentrates

☐ I am uncertain

Type of medicine preferred? *(Please check what applies)*

☐ High THC ☐ Low THC ☐ High CBD ☐ Low CBD ☐ 1:1 Ratio THC / CBD

☐ I am NOT sure of my medical needs

Preferred Medical Marijuana Products, if any:

PRIVACY POLICY AND PRACTICES

As a patient of Caring Nature Dispensary:

I understand I have rights to privacy of my protected health information as defined by the Health Insurance Portability Act of 1996.

I have been made aware that upon request a copy of Caring Nature's privacy policy is available to me.

Caring Nature has made me aware of their right to change the terms of its Notice of Privacy Practice

Patient Signature ____ Date _____________

AuthorizedPatientRepresentative____

CAREGIVERS:

Relationship ____

Signature ____ Date _____________

MEDICAL CANNABIS ACKNOWLEDGMENT OF DISCLOSURE AND INFORMED CONSENT

Please be advised of the of the following:

Possession or use of this product is unlawful outside of the State of Connecticut

___________ ***Initial Here***

Cannabis-based medicine may have intoxicating effects and has not been analyzed or approved by the united states Food and Drug Administration and was produced without FDA oversight for health, safety, or efficacy. Medical cannabis may contain unknown quantities of active ingredients, impurities or contaminants.

___________ ***Initial Here***

The efficacy and potency of cannabis may very widely depending on the cannabis strain and ingestion method.

___________ ***Initial Here***

If the cannabis is smoked or vaporized: Smoking may be hazardous to your health. Cannabis smoke contains carcinogens and may lead to an increased risk of cancer, tachycardia, hypertension, heart attack, birth defects, brain damage, and lung disease.

___________ ***Initial Here***

If cannabis is eaten or swallowed: This product has been infused with cannabis or active compounds of cannabis. When eaten or swallowed, the intoxicating effects of this drug may be delayed by two or three hours or more.

___________ ***Initial Here***

There is limited information on the side effects of using cannabis, and there may be associated health risks. Side effects of cannabis can include, but are not limited to:

- Memory loss
- Dry Mouth
- Sexual Impotence
- Low blood pressure
- Confusion
- Hunger/Loss of appetite
- Cough/Bronchitis/Shortness of breath
- Depression
- Feelings of euphoria
- Drowsiness/ Fatigue/Abnormal Sleep
- Sedation/slower reaction time/Inability to concentrate
- Suppression of immune system
- Anxiety/Nervousness
- Irregular/Increased heart rate
- Numbness
- Agitation
- Poor physical condition
- Dizziness/Impairment of motor skills
- Dependency
- Impaired vision
- Laryngitis/Bronchitis/General Apathy
- Headache/Nausea/Vomiting
- Paranoia/Psychotic Symptoms

Symptoms of cannabis overdose include, but are not limited to, nausea, vomiting, and disturbances to heart rhythm.

This acknowledgment of disclosure is to advise you of risks and side effects of using cannabis medicines. It is important you review this document and discuss any questions you may have with the dispensary pharmacist.

Please do not sign this agreement if you do not understand the information you have received or not comfortable with the risks that may be related to cannabis use or possession.

Patient Signature ____ Date _______________

MEDICAL CANNABIS PATIENT AGREEMENT

I agree that the following statements are true and accurate:

I am over 18 years of age and I am registered with and understand the requirements of the State of Connecticut's medical marijuana program.

I agree to strictly comply with the regulations, terms and conditions of the State of Connecticut's medical marijuana program. No cannabis obtained by me shall be used for any other purpose than as directed by my certifying physician. I understand cannabis is not to be resold, distributed, or used by any other person.

I fully accept the responsibility in using cannabis and I certify I fully understand the potential risks related to the use of cannabis products.

If I start using cannabis, I agree to tell my physician if I experience any one or more of the following:

- Start to feel sad or have crying spells
- Have changes in my normal sleep patterns
- Lose my appetite
- Become more irritable than usual
- Become unusually tired
- Withdrawl from my family and friends
- Lose interest in your usual activities

In the event that I experience a severe adverse reaction, I am advised to immediately contact my physician. In the event that my physician is not available, I agree to call 911 for help, lie down and relax until help arrives.

I agree to tell my physician if I have ever had symptoms of schizophrenia, bipolar disorder, psychotic episodes or attempted suicide. I also agree to tell my medical professional if I have ever been prescribed or taken medicine for any of these problems. I acknowledge that the risks of using cannabis under these circumstances could be severe.

I understand that my physician does not suggest nor condone that I cease treatment of medications that stabilize my mental or physical condition.

I am not pregnant, intending to become pregnant, or breastfeeding.

I certify that I have read this document and declare that the information contained herein is true, correct and complete.

Patient Signature: ___________________________________ Date:_____________________

--- FOR OFFICE USE ONLY ---

I was not able to obtain patient or patient representative signature.

Employee name ____

Date _______________

Reason____

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