Caring Nature

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
- ☐ Chronic Neuropathic Pain associated with Degenerative Spinal Disorders
- ☐ Chronic Pain at least 6mos. Duration associated w/specified underlying chronic condition refractory to other treatment intervention
- ☐ 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
- ☐ Ethlos-Danlos Syndrome associated with Chronic Pain
- ☐ Fibromyalgia, spasticity/neuropathic pain associated with
- ☐ Glaucoma
- ☐ Hydrocephalus with Intractable Headache
- ☐ Interstitial Cystitis
- ☐ Intractable Headache Syndromes
- ☐ Intractable Neuropathic Pain that is Unresponsive to Standard Medical Treatment
- ☐ Irreversible Spinal Cord Injury with Objective Neurological Indication of Intractable Spasticity
- ☐ MALS Syndrome (Median Arcuate Ligament Syndrome)
- ☐ 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
- ☐ Tourette Syndrome
- ☐ Ulcerative Colitis
- ☐ Uncontrolled Intractable Seizure Disorder
- ☐ Vulvodynia and Vulvar Burning
- ☐ Wasting Syndrome

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

- ☐ Cystic Fibrosis
- ☐ Cerebral Palsy
- ☐ Intractable Neuropathic Pain that is Unresponsive to Standard Medical Treatment
- ☐ Irreversible Spinal Cord Injury with Objective Neurological Indication of Intractable Spasticity
- ☐ Muscular Dystrophy
- ☐ Osteogenesis Imperfecta
- ☐ Severe Epilepsy
- ☐ Terminal Illness Requiring End-of-Life Care
- ☐ Tourette Syndrome
- ☐ 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?

_____

Symptoms that you would like to address for treatment: *(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_____

Caregiver Signature:_____Date_____

Relationship_____

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_____
