CANNABIS PATIENT CLIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a client of .
Information collected about new clients is confidential and will be treated accordingly.

PERSONAL INFORMATION

Patient Name: _____ **Date of Birth**: _____

Street Address: _____

City: _____ **State**: _____ **ZIP Code**: _____

E-Mail: _____ **Gender**: ☐ Male ☐ Female

Home Phone: _____ **Mobile Phone**: _____

MMJ Card Number: _____ **Expiration Date**: _____

MMJ Authorizing Physician: _____

Primary Care Physician: _____

Registered Caregiver (if any): _____ **Phone**: _____

A Registered Caregiver is someone you may appoint to act on your behalf in obtaining medication at the dispensary. If you believe that a caregiver will be necessary, please contact your authorizing physician for registration instructions.

How did you hear about us? _____

CONSUMPTION

Have you tried cannabis before? ☐ Yes ☐ No (If no, skip to the next section)

Indicate your preferred forms of cannabis consumption:

- ☐ Capsules, Pills, Tablets
- ☐ Edibles
- ☐ Patches
- ☐ Powder
- ☐ Smoked
- ☐ Suppositories
- ☐ Tinctures
- ☐ Topical
- ☐ Vaporized
- ☐ Other: _____

Indicate your preferred level of CBD / THC:

☐ High CBD ☐ High THC ☐ 1:1 Ratio CBD to THC
☐ Low CBD ☐ Low THC ☐ Unsure

How much cannabis do you usually consume? _____

Which strains do you prefer? _____

Have you experienced negative effects from cannabis? ☐ Yes ☐ No

- If yes, what effects? _____

Describe how cannabis helps you:

HEALTH

List your qualifying medical condition(s):

List your symptoms including the frequency, severity, and duration of pain:

Symptom	Frequency	Severity	Duration

List the type, duration, and outcome of any treatments you have tried:

Treatment	Duration	Outcome

List the medications you currently take including the dosage and frequency:

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you consume alcohol? ☐ Yes ☐ No

- If yes, how many drinks per week? _____

Do you smoke cigarettes? ☐ Yes ☐ No

- If yes, how many cigarettes per day? _____
- How many years? _____

Do you use any other drugs? ☐ Yes ☐ No

- If yes, what drugs? _____
- How often? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

List your allergies:

ACKNOWLEDGMENT

I acknowledge that I possess specific privacy rights regarding my protected health information as defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I understand that I have the right to review the dispensary's Notice of Privacy Practices prior to signing this form and that the dispensary maintains the right to change the terms of its Notice of Privacy Practices.

Patient Signature: _____ **Date**: _____

Print Name: _____

Authorized Representative: _____ **Date**: _____

Print Name: _____

Relationship: _____