PATIENT INITIAL INTAKE FORM

Date_____

Name _____ Date of Birth* _____Age _____

Cell phone*_____ E-mail address* _____

SSN*: _____-_____-_____

*required information

Medical Problem(s) Needing Cannabis treatment:

Do you have, or have you ever had, any of the following problems:

Heart failure	Yes	No
Atrial fibrillation	Yes	No
Coronary disease or heart attack	Yes	No
Asthma/COPD	Yes	No
Organ transplant	Yes	No
Blood clot	Yes	No

Do you, your siblings, or parents have any of the following:

Bipolar	Yes	No
Schizophrenia	Yes	No
Psychosis	Yes	No

How many days per week do you use cannabis?	
How many times a day do you use cannabis?	
How much cannabis do you use? (puffs per day, grams per day, or ounces per month)	

How did you hear about us? (Internet, Ad, Conference, Referral)

Please read: We may make a preliminary decision to provide care to you based on the answers you have given. It is assumed that these answers are factual. If this is not the case, you may be asked to leave the practice without refund. By signing below you state that you understand these terms.

Patient Signature: _____

Date: _____