CENTRAL COAST MEDICAL RECOMMENDATIONS

PATIENT INTAKE FORM

Patient Information

Name: ______________________________ Date: ______________

Age: ____ Gender: ☐Male ☐Female D.O.B: ______________

Address: ____
City: ______________ State: ____ Zip: ______________
Phone: ______________ State Driver's License or ID#: ______________
E-mail: ______________________________
Occupation: ______________________________

How did you hear about Central Coast Medical Recommendations?

☐ Google ☐ Newspaper ☐ Craigslist ☐ Friend
☐ Website (Please provide name of website)____________ ☐ Other ____________

Have you had a medical marijuana recommendation from a doctor before? ☐ Yes ☐ No

Your Primary Care Physician Information

Name: ______________________________
Address: ______________________________
City: ______________ State: ____ Zip: ________
Phone: ______________ Fax: ______________________

Past Medical History

Please list any medical condition that you have ever been evaluated by a physician, admitted to a hospital or are currently being treated for: (For example: HIV / AIDS, arthritis, cancer, glaucoma, migraine headaches, weight loss / anorexia, muscle spasms, seizures, severe nausea, high blood pressure, depression, anxiety, heartburn, irritable bowel, chronic bronchitis, asthma, chronic allergies, or any other disease affecting the kidneys, liver, nervous system, bladder, etc.)

____
____
____
____
____
____
____

Past Surgical History

Please list any surgeries that you have had in the past. Include the reason, date, hospital, and doctor who performed the surgery.

____
____
____

CENTRAL COAST MEDICAL RECOMMENDATIONS

PATIENT INTAKE FORM

Are you allergic to any medications? ☐ Yes ☐ No

If you answered "Yes" to the question above, please list the medications you are allergic to.

____

____

Current Medications

Please list the medications that you are currently taking on a daily or occasional basis (please include over- the counter medications such as Claritin). Include the dosage and frequency of use.

____

____

____

____

____

Do you smoke cigarettes? ☐ Yes ☐ No

If you answered "Yes" to the question above, how much do you smoke? ______________________

Review of Symptoms

General

☐ Dizziness
☐ Headache
☐ Loss of Sleep
☐ Loss of Weight
☐ Nervousness

Gastrointestinal

☐ Abdominal pain or cramps
☐ Poor Appetite
☐ Bowel Changes
☐ Nausea
☐ Vomiting

Muscle / Joint / Bone

☐ Arms ☐ Hips
☐ Back ☐ Legs
☐ Feet ☐ Neck
☐ Hands ☐ Shoulders
☐ Arthritis ☐ Muscle Cramps

Psychiatric

☐ Anxiety
☐ Depression
☐ Disturbing Feelings
☐ Panic Attacks
☐ Restlessness

Cardiovascular

☐ Cardiac Palpitations
☐ High Blood Pressure
☐ Rapid Heart Beat
☐ Irregular Heart Beat

Neurological

☐ Fainting
☐ Headache
☐ Numbness
☐ Seizures

Conditions

☐ AIDS ☐ Chemical Dependency ☐ Multiple Sclerosis ☐ Alcoholism
☐ HIV Positive ☐ Epilepsy ☐ Arthritis ☐ Migraine
Headaches ☐ Fibromyalgia ☐ Cancer ☐ Crohn's Disease
☐ Anorexia

OTHERS: ____

CENTRAL COAST MEDICAL RECOMMENDATIONS

PATIENT INTAKE FORM

Chief Complaint

Please describe the medical condition or complaint that you are seeking a recommendation for medical marijuana. Please include when you first noticed the symptoms and when you received the diagnosis.

____

____

____

____

Does this medical condition limit your ability to conduct major life activities (working, eating, sleeping, interacting with others)? Please describe:

____

____

____

____

Do you feel that if this medical condition is not alleviated, that it could serious harm to your safety, physical, or mental health? ☐ Yes ☐ No

Have you received medical care or been evaluated by a physician for this medical condition?
☐ Yes ☐ No

If yes, please provide the name, address, and date last seen by the physician (including chiropractor / acupuncturist) that diagnosed and / or treated you for this medical condition.

____

____

____

____

If not listed above, please describe all treatments that you have received to date for your current medical problems such as the medications prescribed, surgeries, physical therapy, acupuncture, homeopathy, chiropractic care or other.

____

____

____

____

CENTRAL COAST MEDICAL RECOMMENDATIONS

PATIENT INTAKE FORM

Cannabis (Marijuana) History

Do you currently use cannabis to treat your current medical condition? ☐ Yes ☐ No

At what age did you discover that cannabis eased your medical symptoms? __________

Does cannabis provide relief for your symptoms? (If yes, please describe, i.e., less pain or nausea)

____

____

____

How often do you use marijuana? ☐ Daily ☐ Weekly ☐ Monthly

How much cannabis do you consume per treatment? ____

What method do you currently use to consume the cannabis?
☐ Vaporize ☐ Ingest ☐ Smoke ☐ Anointing Oil

Legal History

Are you currently on probation or parole? ☐ Yes ☐ No
Do you have a pending cannabis case? ☐ Yes ☐ No

Additional Information

Please provide any other information you believe is relevant to the doctor's evaluation.

____

____

____

Are you now or were you ever employed by any city, state, or federal government agency or department? ☐ Yes ☐ No

If you answered "yes" to the question above, please explain.

____

____

____

I understand that the Physician may be contacted to verify and / or authorize my status as their patient as well as any prescription and / or recommendation that may or may not be issued by them. By signing below, I hereby authorize the physician and / or Central Coast Medical Recommendations to make such verifications or authorization. My signature below shall serve as a release for this purpose only and shall not serve as a waiver of my other patient and physician privacy rights as detailed under California State Laws and Federal HIPAA regulations.

I understand if the physician requests medical records, follow up appointments, prescription medications or anything else pertaining to my medical marijuana recommendation, my recommendation will become null and void if the request is not fulfilled within thirty (30) days.

Patient Signature: ______________________________ Date: ________________________