Quintessential Care
A Holistic Medical Marijuana Practice

Intake Forms

for

New Patients

Revised 04/24/2019

IMPORTANT: All pages must be completed and returned to our office prior to your scheduled appointment. If you have any questions regarding these forms, please contact us prior to your appointment so we may assist you. Incomplete forms may delay medical cannabis treatments.

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This is the Medical Cannabis Physicians patient intake questionnaire. To be considered for medical Marijuana, all information must be provided:

Name_____ Date_____ DOB_____
Address_____
County_____ Fl Drivers License #_____
Height_____Weight_____

SSN _____Phone #_____
Email address_____ Primary Care Physician and phone number_____

Reason for cannabis treatment (circle one or more) •Muscle Spasms •Seizures •Cancer •Glaucoma •Crohn's Disease •HIV/AIDS •PTSD •ALS •Parkinson's Disease •Multiple Sclerosis •Terminal illness •Severe Nausea •Paraplegia •Quadriplegia •Chronic Pain •Other debilitating illness (explain)_____

Please list symptoms you experience, frequency, severity and duration

	Symptom	Frequency	Severity	Duration
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Please list all treatments you've tried, how long was each treatment attempted, and outcomes of each treatment

Treatment	Duration	Outcome
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Please list all your medical illnesses:

1._____	5._____	9._____
2._____	6._____	10._____
3._____	7._____	11._____
4._____	8._____	12._____

Please list all current medications dosage and how many times a day

List **ALL MEDICATIONS** you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

Name of Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	Alcoholism	Allergies	Anemia
Anxiety	Arrhythmia	Arthritis	Asthma
Bladder Problems	Bipolar	Bleeding Problems	Crohn's Disease
COPD/ Emphysema	Cancer: _____	DVT (Blood Clot)	Diabetes: 1 or 2
Depression	Diverticulitis	Dementia	Glaucoma
GERD (Acid Reflux)	HIV	High Cholesterol	Heart Disease
Hiatal Hernia	High Blood Pressure	Headaches	Incontinence
Hepatitis	Irritable Bowel Syndrome	Kidney Stones	Kidney Disease
Liver Disease	Lupus	Macular Degeneration	Neuropathy
Osteopenia Osteoporosis	Pulmonary Embolism (PE)	Peripheral Vascular Disease	Peptic Ulcer
Psoriasis	Parkinson's Disease	Heart Attack (MI)	Ulcerative Colitis
Sleep Apnea Arthritis	Seizure Disorder	Stroke	Thyroid Disorder

Last Menstrual Period
Date: _____

Colonoscopy
Yes/No Date:_____
Normal Abnormal

Mammogram
Yes/No Date:_____
Normal Abnormal

Dexa (Bone Density)
Yes/No Date:_____
Normal Abnormal

Pap
Yes/No Date:_____
Normal Abnormal

Surgical History: Please list all prior surgeries and approximate dates performed.

_____
_____
_____
_____

Please list any allergies:

_____
_____

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate

Are there any vision problems that affect your communication? ☐Yes ☐ No

Are there any hearing problems that affect your communication? ☐Yes ☐ No

Do you smoke cigarettes? y/n how much _____ how many years_____

Do you drink alcohol? y/n how much_____ how often_____
Do you use illegal drugs? y/n type_____ How often_____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type:

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____
_____

Please list any other medical history not mentioned above:

_____
_____
_____

Patient Signature: _____

Date: _____