New Patient Information Form

Patient Information

Last Name		First Name	
Street			
City		State	Zip
Cell Phone #			
Email **Can we contact you via Email for our newsletter, product information, promotions, and pre-orders?** □ **Yes** □ **No**			
Birthdate (mm/dd/yyyy)	Age		Gender □ M □ F

Connecticut Medical Marijuana Card Information

CT MMP #	MMP Card Expiration
Driver's License #	

Caregiver Contact Information (if applicable)

Name of Caregiver	
Address (optional)	Can they drive?
Primary Phone # (cell)	Alternate Phone #

Prescribing Physician Information

Name	Office #	
Address		
City	State	Zip

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Last Name ______________________________________ First Name ______________________________________

Health History

Drug Allergies (If you have any allergies, please list them below with the reaction)

1. □ Rash / Hives / Swelling □ Other
2. □ Rash / Hives / Swelling □ Other
3. □ Rash / Hives / Swelling □ Other

List of ALL medications with doses you are currently taking

1.	2.
3.	4.
5.	6.

What medications have you tried in the past that either caused side effects or was ineffective?

Med:	Effect:	Med:	Effect:
Med:	Effect:	Med:	Effect:
Med:	Effect:	Med:	Effect:
Med:	Effect:	Med:	Effect:

Past Medical History (Disease States)

1.	2.
3.	4.
5.	6.

Past Surgical History (List all surgeries you have had and the approximate year)

1.	2.
3.	4.
5.	6.

Social History

Do you consume alcohol? □ Yes □ No If yes, how many drinks ____ / week?

Do you smoke or have tried tobacco? □ Yes □ No If yes, how many / day?

Are you taking any herbal products? □ Yes □ No If yes, what are they?

Do you take any vitamins & minerals? □ Yes □ No If yes, what are they?

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Medical Marijuana Background Information

DIAGNOSIS >18 years of age – CHECK ALL THAT APPLY

□ Cancer □ Multiple Sclerosis □ Crohn's Disease □ Complex Regional Pain Syndrome (CRPS)

□ Glaucoma □ Epilepsy □ PTSD

□ HIV / AIDS □ Cachexia □ Sickle Cell Disease □ Cerebral Palsy

□ Parkinson's Disease □ Wasting Syndrome □ Ulcerative Colitis □ Cystic Fibrosis

□ Severe Psoriasis & Psoriasis Arthritis □ Amyotrophic Lateral Sclerosis

□ Nerve Tissue Damage of Spinal Cord / Spasticity □ Post Laminectomy Syndrome with Chronic Radiculopathy

□ Palliative Care / Terminal Illness requiring End-of-Life □ Uncontrolled Intractable Seizure Disorder

□ Irreversible Spinal Cord Injury with Objective Neurological Indication of Intractable Spasticity

DIAGNOSIS <18 years of age – CHECK ALL THAT APPLY

□ Cerebral Palsy □ Severe Epilepsy □ Irreversible Spinal Cord Injury with Intractable Spasticity

□ Cystic Fibrosis □ Uncontrolled Seizures □ Terminal End-of-Life Care

SYMPTOMS you are experiencing

□ Anxiety / Stress □ Dizziness □ Stomach ache □ Constipation

□ Joint Pain □ Blurred Vision □ Loss of Appetite □ Skin Rashes

□ Headaches □ Acid Reflux / Heartburn □ Weight Gain □ Depression

□ Neck or Back Pain □ Abdominal Cramps □ Chronic Cough □ Urinary Problems

□ Shooting Pain (nerve) □ Muscle Spasms □ Nausea / Vomiting □ Tremors

□ Insomnia / Sleeping Disorders (falling or staying asleep) □ Numbness / Tingling in Fingers and Toes

□ Other

How long have you had the above symptoms? What is the frequency of the symptoms? /week

What have you tried to alleviate the symptoms? CHECK ALL that apply below

□ Acupuncture □ Chiropractor □ Physical Therapy □ Massage Therapy

□ Reiki □ Ayurvedic Medicine □ Other

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Medical Marijuana Use
Have you used Marijuana in the past? ☐ Yes ☐ No If yes, ☐ Medicinal ☐ Recreational
Do you prefer : ☐ Sativa strain ☐ Indica strain ☐ Hybrid ☐ Unsure
What type of product do you prefer? ☐ High THC ☐ Low THC ☐ High CBD ☐ Low CBD ☐ 1:1 ratio of THC to CBD
What form of administration do you prefer? ☐ Inhaled –Smoking ☐ Inhaled –Vaporized ☐ Edibiles ☐ Topicals ☐ Oils ☐ Concentrates ☐ Other
☐ How many times a day do you use the product?
☐ What flavor / aroma do you: ☐ like ☐ dislike