MMJ PATIENT INTAKE FORM

Please complete this form and fax to 917-522-9678 or email to 420CardNYC@gmail.com. Please include copy of your NY State Driver's License or Non-Driver ID.

The consultation fee is $150. I accept credit cards, debit cards, PayPal, Venmo & Zelle.

Date:_____

Name:_____

DOB:_____

Address:_____

Email:_____

Cell phone:_____ Home phone:_____

NY Driver's License or non-driver ID #:_____

Emergency contact:_____

Emergency contact phone:_____

Emergency contact email:_____

Relationship:_____

PCP name:_____

PCP address:_____

PCP phone:_____ PCP fax:_____

PCP email:_____

What is your primary reason for needing medical marijuana?

☐ Chronic Pain ☐ Migraines/headaches ☐ Dysmenorrhea, Fibroids, Endometriosis
☐ P.T.S.D. ☐ Anxiety ☐ Depression ☐ Insomnia ☐ Panic attacks
☐ Nausea, vomiting, poor appetite ☐I.B.S., I.B.D., Crohn's Disease, Colitis
☐ Opioid Use Disorder/Substance Use Disorder ☐ Cancer ☐ HIV+ or AIDS
☐ Epilepsy/Seizure Disorder ☐ Neuropathy/Radiculopathy
☐ Parkinson's Disease ☐ Multiple Sclerosis ☐ Huntington's Disease ☐ A.L.S.
☐ Other_____

Please elaborate on your current condition & symptoms that you are having:_____

_____

List current or past Psychiatric conditions:_____

_____

List any traumatic injuries:_____

_____

List current and past medical conditions:_____

_____

List dates and type of surgeries that you've had:_____

_____

List dates and reason for hospitalizations:_____

_____

List your current medications:_____

_____

List your allergies:_____

Do you use tobacco? ☐ yes ☐ no If yes, how much?_____

Do you drink alcohol? ☐ yes ☐ no If yes, how much?_____

Do you use Cannabis? ☐ yes ☐ no If yes, which type & how much?_____

Do you have a history of substance abuse? ☐ yes ☐ no Which type?_____

Are you currently employed? ☐ yes ☐ no

What is your current profession?_____

Do you get drug tested at work? ☐ yes ☐ no

Have you ever had a DWI? ☐ yes ☐ no

Have you ever been arrested for a drug or alcohol related crime? ☐ yes ☐ no

Are you currently on Parole or Probation? ☐ yes ☐ no

PATIENT AGREEMENT AND CONSENT FORM TO USE MEDICAL MARIJUANA

I understand that under the Controlled Substance Act of 1970 cannabis is categorized as Schedule I, defining it as highly addictive and having potential for abuse; it may contain unknown quantities of active ingredients and/or other impurities.

I understand that cannabis is a medicine used in treating the suffering caused by serious and debilitating medical conditions.

I understand that cannabis smoke contains chemicals such as tars that may be harmful to my health and known carcinogens that may increase the risk of respiratory diseases and cancers of the lungs, mouth and tongue.

I acknowledge that I have been advised not to drive vehicles, operate machinery, or participate in any activity that requires safe judgment or analytical abilities while under the influence of cannabis.

I understand that there are potential risks combining alcohol/other substances and medications with cannabis. I assume any such risks and responsibilities and will discontinue cannabis use if I notice any unwanted symptoms or side effects. These effects can include, but are not limited to nausea, lethargy, upper respiratory problems, difficulty with short term memory, anxiety, headaches, paranoia, loss of coordination, and psychological dependence on cannabis. I understand that withdrawal symptoms may occur upon discontinuing its use. These may include feelings of depression, sadness or irritability, restlessness or mild agitation, insomnia, sleep disturbance, unusual tiredness, trouble concentrating, and loss of appetite.

I understand that under the laws of New York State, a medical marijuana recommendation from a Physician or Nurse Practitioner must be fully valid and that I must abide by the possession and usage requirements outlined by my respective State law.

I understand that the recommendation expires on the date specified at the time of the recommendation. I understand that it is my responsibility to see my Physician or Nurse Practitioner to assess the possible continuance of medical marijuana use beyond the expiration date. Any unauthorized release of information in this record is forbidden under federal HIPAA laws and I understand that I have only authorized this practice to confirm the following identifying information: name, date(s) seen, date of birth, date of expiration, and diagnose(s).

RELEASE OF LIABILITY

The Nurse Practitioner of this practice is addressing specific aspects of my medical care and are in no way establishing themselves as my primary care provider. The Nurse Practitioner is providing medical advice regarding the therapeutic value of the use of medical marijuana. Furthermore, the undersigned or anyone acting on my behalf, hold the Nurse Practitioner free of and harmless from any responsibility for any harm resulting to me and/or other individuals in a result of my cannabis use.

SIGNATURE:_____ DATE:_____

PRINT NAME:_____