Organic Remedies
DISPENSARY

INITIAL PATIENT INTAKE FORM

NAME: _____

Date of Birth: ____ / _____/_____ **Gender**: ☐ Male ☐ Female

Address: _____

City: _____: **State**: _____ **Zip Code**: _____

Preferred method of contact. For internal use only.

Home Phone: _____ ☐ Morning ☐ Afternoon ☐ Evening

Cell Phone: _____ ☐ Morning ☐ Afternoon ☐ Evening

Email: _____

Primary Care Physician: _____

MMJ Authorized Physician: _____

Registered Caregiver (if applicable):_____ Phone Number: _____

A Registered Caregiver is a person chosen by the patient to act as their agent in obtaining their medication at the dispensary. If you feel that you need a caregiver, please contact your qualifying physician.

How did you hear about us?

☐ Website ☐ Department of Consumer Protection ☐ News Article
☐ Leafly ☐ Referred ☐ Search Engine

My State Approved Diagnosis: (Please check what applies below)

☐ Amyotrophic Lateral Sclerosis (ALS) ☐ Autism ☐ Cancer
☐ Crohn's Disease ☐ Damage to the Nervous Tissue of the Spinal Cord with Objective Neurological Indication of Intractable Spasticity ☐ Epilepsy ☐ Glaucoma
☐ Positive for HIV/AIDS ☐ Huntington's disease ☐ IBS ☐ Intractable Seizures
☐ Multiple Sclerosis ☐ Neuropathies ☐ Parkinson's disease ☐ PTSD
☐ Severe chronic or intractable pain of neuropathic origin or severe chronic or intractable pain in which conventional therapeutic intervention and opiate is contraindicated or ineffective
☐ Sickle Cell Anemia

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Negative symptoms that I am currently experiencing: (Please check what applies below)

☐ Abdominal Pain / Cramping
☐ Anxiety
☐ Depression
☐ Difficulty Falling Sleeping
☐ Difficulty Remaining Asleep
☐ General Insomnia
☐ General Pain
☐ Hyperactive Bowels
☐ Migraine
☐ Ocular Pressure
☐ Muscle Pain
☐ Nausea
☐ Tremors
☐ Poor Appetite
☐ Seizures
☐ Other: _____

Frequency of Symptoms: _____
_____

Additional Health Conditions: _____
_____
_____
_____

Current Medication	Dosage

Allergies: _____

Alternate Medicine	Vitamins

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Do you smoke Tobacco? (Please check one): ☐ Yes ☐ No

Do you drink Alcohol? (Please check one): ☐ Yes ☐ No

I have used Cannabis (Marijuana) prior to this visit: ☐ Yes ☐ No

Please Describe, If Applicable Negative Effects Experienced using Cannabis (if applicable): _____

_____

Positive Effects Experienced using Cannabis (if applicable): _____

_____

Positive outcomes I hope to achieve using Medical Cannabis: _____

_____

My Preferred Method of Cannabis Consumption: (Please check what applies below)

☐ Vaporizing ☐ Oils ☐ Tinctures ☐ Concentrates ☐ Capsules

☐ I am uncertain

I am looking for Cannabis with: (Please check what applies below)

☐ High THC ☐ Low THC ☐ High CBD ☐ Low CBD

☐ 1:1 Ratio THC / CBD ☐ I am NOT sure of my medical needs

Frequency of use (if applicable): _____

_____

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NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient Name:_____ Date of Birth: _____

I understand, that under the Health Insurance Portability Act of 1996, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read, and understand the Notice of Privacy Practices. Organic Remedies reserves the right to change the terms of its Notice of Privacy Practices. I understand Organic Remedies will provide a current Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Authorized Patient's Representative: _____

Relationship: _____

Signature: _____

---------- FOR OFFICE USE ONLY ----------

I was unable to obtain the patient / patient's representative's signature.

Employee's Name:_____ Date: _____

Reason: _____