



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)

- | | | |
|---|--|---|
| <input type="radio"/> Amyotrophic Lateral Sclerosis (ALS) | <input type="radio"/> Epilepsy | <input type="radio"/> Opioid Use Disorder |
| <input type="radio"/> Anxiety | <input type="radio"/> Glaucoma | <input type="radio"/> Parkinson's Disease |
| <input type="radio"/> Autism | <input type="radio"/> Huntington's Disease | <input type="radio"/> PTSD |
| <input type="radio"/> Cancer | <input type="radio"/> IBD | <input type="radio"/> Positive for HIV/AIDS |
| <input type="radio"/> Crohn's Disease | <input type="radio"/> Intractable Seizures | <input type="radio"/> Sickle Cell Anemia |
| <input type="radio"/> Chronic Pain | <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Spinal Cord Injury |
| <input type="radio"/> Dyskinetic and Spastic Movement Disorders | <input type="radio"/> Neuropathies | <input type="radio"/> Terminal Illness |
| | <input type="radio"/> Neurodegenerative | <input type="radio"/> Tourette Syndrome |

INITIAL PATIENT INTAKE FORM

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Abdominal Pain / Cramping | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Difficulty Falling Sleeping | <input type="checkbox"/> Difficulty Remaining Asleep | <input type="checkbox"/> General Insomnia |
| <input type="checkbox"/> General Pain | <input type="checkbox"/> Hyperactive Bowels | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Ocular Pressure | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Other: _____ | | |

Frequency of Symptoms: _____

Additional Health Conditions: _____

Current Medication	Dosage

Allergies: _____

Alternate Medicine	Vitamins

INITIAL PATIENT INTAKE FORM

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

I am a regular user of cannabis: 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): _____

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: _____