INITIAL PATIENT INTAKE FORM

Patient Name: _____ **Goes By:** _____

DOB: ___/___/_____ **Gender:** _____ **Preferred Pronouns:** _____

Address: _____

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

Cell Phone: _____ **Home Phone (if different)**:_____

Email: _____

Would you like to be signed up for text alerts? (Standard Messaging Rates Apply) ☐ Yes ☐ No

Would you like to receive email newsletters? ☐ Yes ☐ No

How did you hear about us?

☐ Friends/Family ☐ Provider Referral ☐ Drove by location
☐ Internet Search ☐ Social Media ☐ Billboard

Primary Care Physician: _____

MMJ Authorizing 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 have them register through the Department of Health for their card.

My State Approved Diagnosis: (Please check all that apply below)

☐ Amyotrophic Lateral Sclerosis (ALS) ☐ Anxiety Disorders ☐ Autism
☐ Cancer (including remission therapy) ☐ Crohn's Disease ☐ Chronic Pain
☐ Dyskinetic and Spastic Movement ☐ Epilepsy ☐ Glaucoma
☐ HIV/AIDS ☐ Huntington's Disease ☐ Inflammatory Bowel Disease (IBD)
☐ Intractable Seizures ☐ Multiple Sclerosis (MS) ☐ Neurodegenerative Diseases
☐ Neuropathies ☐ Opioid Use Disorder ☐ Parkinson's Disease
☐ Post-Traumatic Stress Disorder (PTSD) ☐ Sickle Cell Anemia ☐ Terminal Illness
☐ Tourette Syndrome
☐ Chronic Hepatitis C

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Negative symptoms that I am currently experiencing: (Please check all that apply below)

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

Frequency of Symptoms: _____

_____

Additional Health Conditions: _____

_____

Current Medications (include a separate sheet if needed):

Prescribed Medication	Dosage

Alternate Medicine	Vitamins

Allergies (Please include all types of allergies. i.e., Medication, Food, Plant, Etc.): _____

_____

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Do you use Tobacco?	☐ Yes	☐ No		
Do you consume Alcohol?	☐ Yes	☐ No		
I am or plan to become pregnant and/or breastfeeding?	☐ Yes	☐ No	☐ N/A	
I have used Cannabis (Marijuana) in the past:	☐ Yes	☐ No		
Frequency of Cannabis (Marijuana) use:	☐ Daily	☐ Weekly	☐ Monthly	☐ N/A

Please describe any negative effects experienced when using Cannabis (Marijuana) (If Applicable):

_____

_____

Please describe any positive effects experienced when using Cannabis (Marijuana) (If Applicable):

_____

_____

What are the positive outcomes you hope to achieve using Cannabis (Marijuana): _____

_____

_____

My Preferred Method of Cannabis (Marijuana) Consumption: (Please check all that apply below)

☐ Vaporization (Inhalation)	☐ Capsules	☐ Tinctures
☐ Concentrates	☐ Topicals	☐ I am uncertain

I am looking for Cannabis (Marijuana) with: (Please check all that apply below)

☐ High THC	☐ High CBD	☐ Ratio of THC/CBD
☐ Low THC	☐ Low CBD	☐ I am unsure of my medical needs

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NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I understand, that under the Health Insurance Portability Act of 1996, I have certain rights to privacy in regard to my protected health information (PHI). I have received the Notice of Privacy Practices via Organic Remedies Website. 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 on their website.

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: _____

INITIAL PATIENT INTAKE FORM

Patient & Caregiver Purchase Disclosures

- Organic Remedies requires all patients new to medical marijuana therapy to receive a pharmacist consult and encourage all patients new to our location to also receive a consult with our pharmacists. However, if you have received a consult with a pharmacist at another location prior to visiting us, you may opt to waive a consult and purchase product. Our pharmacists are always available for follow-up consults as needed to help maximize your therapy.

  _____I am a new patient/caregiver and require a pharmacist consult.
- Patient/Caregiver agrees not to open or consume medical marijuana within 1000 feet of the facility or in any other place prohibited by law and medical marijuana must be kept in the original packaging with all labels intact. Management recommends that you open your medical marijuana in private, at home or in a similar environment.

- Under the law of the Commonwealth of Pennsylvania, I understand that I am not immune from the imposition of any civil, criminal, or other penalties for:
  - Operating, navigating, or being in physical control of any motor vehicle, boat, or aircraft while under the influence of medical marijuana.
  - Consumption of medical marijuana in any public place
  - Consumption of medical marijuana in a motor vehicle
  - Undertaking any task under the influence of medical marijuana when doing so would constitute negligence or professional malpractice.

- It is unlawful for anyone other than the Patient/Caregiver to possess or use medical marijuana. I understand it is illegal to divert, transfer, sell, or give this or any medical marijuana products to anyone other than the Patient/Caregiver to whom it was dispensed. I agree to keep all medical marijuana away from children, other than the patient.

- It is unlawful under Federal Law, to possess, use, manufacture or distribute Marijuana. I understand obtaining medical marijuana under Pennsylvania Law and regulations does not exempt me from Federal prosecution, under the laws and penalties provided by the Federal government.

- I understand that scientific research has not established the safety of medical marijuana use by pregnant women and nursing mothers.

- The FDA Center for Drug Evaluation and Research ensures drugs marketed in the United States are safe and effective. Because Medical marijuana remains a Schedule 1 substance under the Controlled Substance Act, it has not received FDA approval. I understand the use of medical marijuana to treat a medical condition is not yet approved by the U.S Food and Drug administration.

I confirm I have read, understand, acknowledge, and affirm the above statements. My signature below documents my understanding and acknowledgment of this information.

_____ _____

(Signature) (Date)

_____

(Print Name)