INITIAL PATIENT INTAKE FORM

Name: _____ _____
Last Name First Name

Date of Birth: MM / DD / YYYY **Gender:** ☐ Male ☐ Female

Address: _____

Town: _____ **State:** _____ **Zip Code:** _____

Preferred method of contact. For internal promotional use only.

Home Phone: _____ ☐ Morning ☐ Afternoon ☐ Evening

Cell Phone: _____ ☐ Morning ☐ Afternoon ☐ Evening

Carrier (e.g. Verizon, AT&T): _____ **Email** _____

Primary Care Physician: _____

MMJ Authorized Physician: _____
Doctor who qualified you for the Medical Marijuana Program

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.

Are you a veteran? (Please check one) ☐ Yes ☐ No *IF YES, PLEASE PROVIDE DOCUMENTATION*

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) ☐ Cachexia ☐ Cancer

☐ Complex Regional Pain Syndrome ☐ Crohn's Disease

☐ Damage to the Nervous Tissue of the Spinal Cord with Objective Neurological Indication of Intractable Spasticity

☐ Epilepsy ☐ Glaucoma ☐ Multiple Sclerosis

☐ Parkinson's Disease ☐ Positive for HIV or AIDS

My State Approved Diagnosis: (continued from previous page - please check what applies below)

☐ Post Laminectomy Syndrome w/ Chronic Radiculopathy

☐ Post-Traumatic Stress Disorder (PTSD) ☐ Severe Psoriasis & Psroritatic Arthitis

☐ Ulcerative Colitis ☐ Wasting Syndrome ☐ Sickle Cell Disease

Please Note: Additional conditions will be added over time, please check the department of Consumer Protection website for changes to the list at www.ct.gov/dcp

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

☐ Muscle Pain ☐ Muscle Pain ☐ Nausea

☐ Ocular Pressure ☐ Poor Appetite ☐ Seizures

☐ Tremors ☐ Other: _____

Frequency of Symptoms:

_____

Additional Health Conditions:

_____

_____

_____

_____

Current Medication	**Dosage**

Allergies:

_____

_____

_____

_____

Alternate Medicine	Vitamins

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)

☐ Smoking ☐ Vaporizing ☐ Consumables (Edibles)

☐ Oils ☐ Tinctures ☐ Concentrates

☐ 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.

Yolo Laser Center and Med Spa reserves the right to change the terms of its Notice of Privacy Practices. I understand Yolo Laser Center and Med Spa will provide a current Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Authorized Patient's Representative: _____

Relationship: _____

Signature: _____ Date: _____

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

Employee's Name: _____ Date: _____

Reason: _____

Acknowledgement of Disclosure and Assumption of Risk Agreement

This Acknowledgement of Disclosure and Assumption of Risk Agreement has been prepared to provide you with information regarding the risks and side effects of using cannabis (also referred to as "**marijuana**"). It is important that you read this information carefully and completely. Please discuss any questions you may have with the dispensary pharmacist or your certifying physician. Once you have read and understand the attached information, and have had any questions addressed to your satisfaction, please sign and date the Acknowledgement of Disclosure and Assumption Risk Agreement.

Do not sign this Agreement and do not use cannabis if you have questions about or do not understand the information you have received or are not comfortable assuming the risks that may be associated with cannabis use or possession.

Risks and Side Effects of Cannabis Use

Possession or use of this product is unlawful outside of the State of Connecticut and prohibited by federal law.

Cannabis may have intoxicating effects and has not been analyzed or approved by the United States Food and Drug Administration ("**FDA")** and was produced without FDA oversight for health, safety, or efficacy. Cannabis may contain unknown quantities of active ingredients, impurities, or contaminants.

The efficacy and potency of cannabis may vary widely depending on the cannabis strain and ingestion method.

If cannabis is smoked or vaporized: Smoking may be hazardous to your health. Cannabis smoke contains carcinogens and may lead to an increased risk of cancer, tachycardia, hypertension, heart attack, birth defects, brain damage, and lung disease.

If cannabis is eaten or swallowed: When products infused with cannabis or active compounds of cannabis are eaten or swallowed, the intoxicating effects of this drug may be delayed by two or three hours or more.

There is limited information on the side effects of using cannabis, and there may be associated health risks. Side effects of cannabis can include, but are not limited to:

- Memory loss
- Anxiety/Nervousness
- Dry mouth
- Irregular/Increased heartbeat
- Sexual impotence
- Numbness
- Low blood pressure
- Agitation
- Confusion
- Poor physical condition
- Hunger/Loss of appetite
- Dizziness/Impairment of motor skills
- Cough/Bronchitis/Shortness of Breath
- Dependency
- Depression
- Impaired vision
- Feelings of euphoria
- Laryngitis/Bronchitis/General Apathy
- Drowsiness/Fatigue/Abnormal sleep
- Headache/Nausea/Vomiting
- Sedation/slower reaction time/Inability to concentrate
- Paranoia/Psychotic Symptoms
- Suppression of immune system

Symptoms of cannabis overdose include, but are not limited to, nausea, vomiting, and disturbances to heart rhythm.

The scientific basis for the medical use of cannabis has not been established. There is little known information regarding how cannabis may or may not react with other pharmaceutical or herbal medications.

Some patients can become dependent on cannabis. This means they experience withdrawal symptoms when they stop using cannabis. Signs of withdrawal symptoms can include feelings of depression, sadness or irritability, restlessness or mild agitation, insomnia, sleep disturbance, unusual tiredness, trouble concentrating, and loss of appetite.

Some users can develop a tolerance to cannabis. This means higher and higher doses are required to achieve the same symptom relief.

The possibility exists that cannabis may exacerbate schizophrenia or bipolar disorder in persons predisposed to those disorders.

Woman should not consume cannabis products while planning to become pregnant, during pregnancy, or while breast feeding, except on the advice of the certifying health practitioner, and in the case of breast feeding mothers, on the advice of the infant's pediatrician. Keep out of the reach of children and pets.

Using cannabis while under the influence of alcohol is not recommended.

The use of cannabis may affect coordination, cognition, and judgement. While under the influence of cannabis, do not drive, operate machinery, or engage in potentially hazardous activities.

Please note that cannabis will degrade over time.

I certify that I have read the above Acknowledgment Disclosure and Assumption of Risk Agreement and I fully understand the potential risks and side effects related to the use of cannabis as described above. In using cannabis for medicinal use, I fully accept responsibility and assume the risks and side effects associated with its use. I further hold harmless and release Prime Wellness of Connecticut of any liability related to any risks.

Patient Signature: _____ Date: _____

Patient Name: _____

Medical Marijuana Program Patient Agreement

I agree that the following statements are true and accurate:

I am over 18 years of age and I am registered with and understand the requirements of the State of Connecticut's medical marijuana program.

I agree to strictly comply with the regulations, terms and conditions of the State of Connecticut's medical marijuana program, including, but not limited to, ensuring that no cannabis obtained by me shall be used for any other purpose than as directed by my certifying physician and such cannabis is not resold, distributed, or otherwise possessed or used by any other person.

I have been advised of the risks and side effects associated with using cannabis by my certifying physician and have decided to assume such risks.

If I start using cannabis, I agree to tell my physician if I experience any one or more of the following:

- Start to feel sad or have crying spells
- Have changes in my normal sleep patterns
- Lose my appetite
- Become more irritable than usual
- Become unusually tired
- Withdraw from my family and friends
- Lose interest in my usual activities

In the event that I experience a severe adverse reaction, I agree to immediately contact my physician. In the event that my physician is not available, I agree to call 911 for help.

I agree to tell my physician if I have ever had symptoms of schizophrenia, bipolar disorder, psychotic episodes or attempted suicide. I also agree to tell my physician if I have ever been prescribed or taken medicine for any of these conditions. I acknowledge that the risks of using cannabis under these circumstances could be severe.

I understand that my physician does not suggest nor condone that I cease treatment of medications that stabilize my mental or physical condition.

I am not pregnant, intending to become pregnant, or breastfeeding.

I certify that I have read this Medical Marijuana Program Patient Agreement and declare that the information contained herein is true, correct, and complete.

Patient Signature: _____ Date: _____

SUBMIT FORM