OCEANSIDE 420 $100

New Patient Intake Form

**Please fill out this form completely. No line should be left blank**.

OFFICE USE ONLY

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_ Sex: M or F *(circle one)*

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CA Driver’s License #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or State ID Card #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Medical Information**

Health Habits: How much Alcohol do you consume each week?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tobacco?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are female, is thereany possibility you could be pregnant? Yes or No*(circle one)*

Is there a family history of any medical problems? If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any surgeries or broken bones? If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list medications, both prescription and over- the- counter:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please listall allergies or side effects to medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(side effects may be one reason to use medical marijuana instead of pills)*

**Your Last Medical Doctor or Clinic Visit**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address, City, State, Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date and Reason for the visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date and Reason for any planned visits:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there is no visit in the past 10 years, please state why:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have Medical Insurance now? Yes or No *(circle one)* If so, what insurance?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If you DO NOT Remember your last doctor’s visit, please write I DO NOT REMEMBER across this section)

**Medical Symptoms/Diagnosis or Reason for Today’s Evaluation**

|  |  |  |  |
| --- | --- | --- | --- |
| I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am here to see the doctor today because I | | | |
| request an evaluation for a medical marijuana recommendation. I believe that the medicinal use of marijuana | | | |
| will relieve my symptoms. I have the following symptoms and/or diagnoses: | | | |
|  | ***(Circle all that apply below:)*** | |  |
|  | **Symptoms** |  | **Symptoms** |
|  | Anxiety / Stress / Insomnia/Rage |  | Nausea/ Vomiting /Abdominal Pain/ Chronic Stomach Upset |
|  | Depressed feelings/Suicidal (Now)? |  | Difficulty Gaining Weight / Lack of Appetite |
|  | Headaches |  | Chronic Cough |
|  | Back Pain/Upper Mid Lower |  | Chest Pain (now)?/Shortness of Breath |
|  | Neck Pain / TMJ Dysfunction |  | Skin Irritation |
|  | Joint Pain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Dizziness / Vision problems / Vertigo |
|  | Muscle spasms:\_\_\_\_\_\_\_\_\_\_\_\_ |  | Urinary problems |
|  | Numbness or tingling in limbs |  | Erectile Dysfunction / Libido |
|  | Menstrual Cramps / Hot Flashes |  | History of Addiction to: |
|  |  |  |  |
|  | **Diagnosis by your Doctor** |  | **Diagnosis by your Doctor** |
|  | AIDS / HIV/Wasting Syndrome |  | Asthma / COPD / Pulmonary Fibrosis |
|  | ADD / ADHD (attention hyperactivity disorder) |  | Arthritis: Rheumatoid / Osteoarthritis / Psoriatic / Gout |
|  | Bipolar/Depression / OCD |  | Cancer of:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Anxiety/Panic disorder |  | Diabetes: Controlled / Uncontrolled HgbA1c?\_\_\_\_\_\_\_\_\_\_\_ |
|  | Schizophrenia / Schizoaffective Disorder |  | Restless Leg Syndrome |
|  | PTSD (post traumatic stress disorder) |  | Epilepsy / Seizures / Traumatic Brain Injury / Stroke |
|  | Heart Disease/High Blood Pressure/A-Fib |  | Hepatitis: B C (c*ircle one)*/ Cirrhosis |
|  | Alzheimer’s/Dementia |  | Kidney Disease/Chronic Interstitial Cystitis /Polycystic Kidney |
|  | Migraine /Tension Headaches |  | Multiple Sclerosis / Cerebral Palsy / Parkinson’s / ALS |
|  | Stomach Ulcers/Ulcerative Colitis / GERD |  | Fibromyalgia / Lupus / Lyme Disease /Auto Immune Disorder |
|  | Crohn’s Disease/IBS/Cyclic Vomiting |  | Psoriasis / Eczema / Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Menopause/ Polycystic Ovarian Syndrome |  | Neuropathy of:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Thyroid Disease / Hashimoto’s |  | Glaucoma/Intraocular Pressure/Macular Degeneration |

**Each Box Marked Above will be discussed at length with Dr. Shore. It takes only ONE to qualify.**

**For what symptoms are you seeking medical marijuana:**

*(It is very important that every line is complete)*

1. What medical issue will you be seeing the doctor for today\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What caused your problem:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. How long have you had these symptoms:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Intensity/Frequency of Symptoms:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. What treatments have you tried for this issue:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wish to be reminded of your renewal ? Y/N

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We are a WiFi Hotspot – Please see the router number and password posted between Dr. Shore and Michelle’s offices.

Complete the entire form, sign, initial and date where applicable then return to Michelle.

**Patient Statement Regarding Primary Diagnosis and Medical Records**

Have you seen a doctor or been to a clinic for your medical symptoms / problems?

Pleasecircle**Yes** or **No** here

1. If you answered YES, then please provide Oceanside 420 Alternative Medicine Evaluation Center with a copy of your medical records, x-rays, and prescriptions from your treating physician / clinic *(the doctor you listed on Page 1)*
2. If you answered YES but CANNOT provide the medical record copies, then please provide the following information:

I cannot provide the records because:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your personal statement regarding the above facts:**

I, (print your name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, confirm that the information provided by me regarding my diagnosis and medical records is true and correct.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient’s Signature Date

**Disclosures and Conditions**

* Based on my beliefs and awareness of researched scientific evidence of the benefits of medical marijuana, I request that the doctor evaluate me for a recommendation to us medical marijuana. This would enable me to legally obtain medical marijuana to use for treatment of my medical conditions.
* If medical marijuana adversely affects my health, I will stop using medical marijuana. I assume all risk for the use of medical cannabis.
* I agree to obtain medical follow-up at my personal medical doctor’s office, or obtain a personal doctor I have none now and to return this office for follow-up as recommended by the physician. I understand this is an obligation on my part for the continuity of care.
* I agree NOT TO DRIVE or operate heavy equipment while using medical marijuana.
* I DO NOT plan or intend to use my physician’s recommendations for the purpose of illegally obtaining medical marijuana.
* I understand that I MUST be a California resident to obtain an approval or recommendation for the use of medical marijuana under California’s Compassionate Use Act of 1996(Health & safety Code 11362.5).
* I affirm that I have a serious medical condition that adversely affects my quality of life.
* I have been assured that medical records relating to my care will be kept private and confidential and that no information will be released or printed, which would disclose my personal identity, unless required by law.
* It should be made absolutely clear that the physician, staff or representatives of this center are neither providing medical marijuana, nor are they encouraging any illegal activity in my obtaining or using medical marijuana.
* Furthermore, the undersigned, my heirs, assignees, or anyone acting on my behalf, hold the physician, the staff or any agents of this center free and harmless of any liability resulting from the use of medical marijuana.

**I have read, understood and affirm all of the above statements.**

**X­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**