Welcome to

Compassionate Health Options

Date: ________

Last Name: ______________________________ First:_________________________ MI: ___

Address: ____________________________ Apt. _____ City: _____________ Zip: ________

Home Phone: _________________________ Cell Phone: ___________________________________

Date of Birth: _____________ Age: _______ Email: _____________________________________

California license/ID number________________________ Expiration Date: ______________________

How did you hear about us? ☐ Friend ☐ Newspaper ☐ Internet ☐ Doctor/Clinic ☐ Other_________

PATIENT AGREEMENT AND CONSENT FORM TO USE MEDICAL MARIJUANA

I understand that under the Controlled Substance Act of 1970 cannabis is categorized as Schedule I, defining it as highly addictive and having potential for abuse; it may contain unknown quantities of active ingredients and/or other impurities.

I understand that cannabis is a medicine used in treating the suffering caused by serious and debilitating medical conditions. I understand that cannabis smoke contains chemicals such as tars that may be harmful to my health, and known carcinogens that may increase the risk of respiratory diseases and cancers of the lungs, mouth and tongue. I acknowledge that I have been advised not to drive vehicles, operate machinery, or participate in any activity that requires safe judgment or analytical abilities while under the influence of cannabis.

I understand that there are potential risks combining alcohol/other substances and medications with cannabis. I assume any such risks and responsibilities and will discontinue cannabis use if I notice any unwanted symptoms or side effects. These effects can include, but are not limited to: nausea, lethargy, upper respiratory problems, difficulty with short term memory, anxiety, headaches, paranoia, loss of coordination, and psychological dependence on cannabis. I understand that withdrawal symptoms may occur upon discontinuing its use. These may include feelings of depression, sadness or irritability, restlessness or mild agitation, insomnia, sleep disturbance, unusual tiredness, trouble concentrating, and loss of appetite.

I understand that under The Compassionate Use Act of 1996 (Prop 215), a medical marijuana recommendation from a physician ensures protection from criminal prosecution or sanction, and applies to California residents. I understand that the recommendation expires on the date specified at the time of the recommendation. I understand that it is my responsibility to see my physician to assess the possible continuance of medical marijuana use beyond the expiration date.

Any unauthorized release of information in this record is forbidden under federal HIPAA laws and I understand that I have only authorized Compassionate Health Options to confirm the following identifying information: name, date(s) seen, date of birth, date of expiration, and diagnose(s).

COMPASSIONATE HEALTH OPTIONS RELEASE OF LIABILITY

The physician, staff, and representatives of Compassionate Health Options are addressing specific aspects of my medical care and are in no way establishing themselves as my primary care provider. The physician is providing medical advice regarding the therapeutic value of the use of medical marijuana. Furthermore, the undersigned or anyone acting on my behalf, hold the physician and his/her agents and employees free of and harmless from any responsibility for any harm resulting to me and/or other individuals in a result of my cannabis use.

I DECLARE UNDER PENALTY OF PERJURY THAT I HAVE READ THIS DOCUMENT AND THAT ALL OF THE INFORMATION ON THIS FORM IS TRUE AND ACCURATE.

Patient Signature: ________________________________ **Date: ________________**

(Parent or Legal Guardian if patient is a minor) ________________________________ Date_______

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices of Compassionate Health Options, and that I have read (or had the opportunity to read if I so chose) this document and understand its contents and agree to its terms.

Patient Signature: ________________________________ **Date: ________________**

(Parent or Legal Guardian if patient is a minor) ________________________________ Date_______

Last Name____________________ **First Name**____________________ **Age**_____ **Date** ___________

Current/Past Health History

Who is your healthcare professional (physician, chiropractor, therapist, etc)?

Name/Clinic____Phone_____________________Fax___________________

When was your last visit to a healthcare provider etc.?____

What did you see this provider for?____

Have you talked to your primary care doctor about medical cannabis? Yes ☐ No ☐
If you haven't, why not? ____

Do you have health insurance? Yes ☐ No ☐ **If yes, what kind?**__________________________________

Please check the problems or conditions for which you are seeking an evaluation:

☐ Chronic Pain ☐ Muscle Spasm ☐ Anorexia
☐ Insomnia ☐ Anxiety/Depression ☐ Glaucoma
☐ Headache ☐ Nausea ☐ Other _________________________________

Check the box that best describes how much these symptoms interfere with your life:

Work	☐ Never	☐ Sometimes	☐ Often	Relationships	☐ Never	☐ Sometimes	☐ Often
Sleep	☐ Never	☐ Sometimes	☐ Often	Physical activity	☐ Never	☐ Sometimes	☐ Often
Mood	☐ Never	☐ Sometimes	☐ Often	Enjoyment of life	☐ Never	☐ Sometimes	☐ Often

Are you currently pregnant? Yes ☐ No ☐ **Are you currently breastfeeding?** Yes ☐ No ☐

Please list any medical conditions:
1.____3.____
2.____4.____

Surgeries/procedures with dates:
1.____3.____
2.____4.____

Current/Previous Medications (include herbs, OTC meds. etc.)

Medications & Dosage	Side Effects	Pharmacy	Date Filled	RX#

Current/Previous Treatments: check all that apply and give approximate dates

____chiropractor ____stretching ____massage therapy
____yoga ____vitamins ____physical therapy
____acupuncture ____exercise ____injections
____meditation ____counseling which of these have helped you the most________________

Cannabis Use

Are you new to cannabis use? Yes ☐ No ☐ How long have you been using cannabis? ________
Have you ever been issued a cannabis recommendation? Yes ☐ No ☐

Please check how cannabis helps you or might help you:

☐ decreases pain ☐ decreases nausea ☐ improves/increases sleep
☐ decreases anxiety/depression ☐ increases appetite ☐ improves relationships
☐ improves ability to work/function ☐ improves overall sense of wellbeing ☐ Other ______________________

How much do you use per day/week/month? (e.g. 1/8 month)_______________________________________

Preferred Method of Medicating:
☐ Pipe ☐ Bong ☐ Joint ☐ Vaporizer ☐ Blunt/spliff ☐ Concentrate(oil,keif) ☐ Edibles ☐ Tincture ☐ Topical

What time during the day do you medicate? Please check all boxes that apply:
☐ Morning ☐ Afternoon ☐ Evening ☐ Night How Often? ☐ Daily ☐ Weekly ☐ Monthly

Last Name___________________ **First Name**___________________ **Age**_____ **Date** ___________

Substance Use

Tobacco:
Do you smoke cigarettes? Y ☐ N ☐ If yes, what age did you start? ________ How many per day?__________
Have you ever tried to quit smoking? Y ☐ N ☐ When? ________ How? ____________________________________

Alcohol:
Do you consume alcoholic beverages? Y ☐ N ☐
How many drinks do you consume a Day? ______ Week? ______ Month? _______
Have you ever had a problem drinking too much alcohol? Y ☐ N ☐ When? ____________________________________
Have you ever attended Alcoholics Anonymous or a similar program? Y ☐ N☐

Other Substances:
Are you currently using or did you in the past use any of the following drugs?
Cocaine Y ☐ N ☐ Amphetamines/Crank Y ☐ N ☐ Opiates Y ☐ N ☐ Mushrooms Y ☐ N ☐
Ecstasy Y ☐ N ☐ Downers/Pills Y ☐ N ☐ LSD/Acid Y ☐ N ☐ Other ___________________________

When and for how long did you use any of these?____

Arrest/Criminal History

Have you ever been arrested? Y ☐ N ☐ If so give details____
I have no criminal record ☐

Social and Family History

In your family, has there been a history of: (check all that apply)
☐ heart disease ☐ high blood pressure ☐ cancer ☐ diabetes ☐ arthritis ☐ depression ☐ alcohol/drug abuse ☐ other ______

Do you eat? (check all that apply)
☐ Meat
☐ Dairy
☐ Processed foods
☐ Fast food
☐ Soda
☐ Coffee
☐ Organics
☐ Special diet (raw food, macro, zone, etc) _______________

What do you do for exercise?
☐ walk
☐ run
☐ bike
☐ sports _____________
☐ other ______________

How many times per week?
____

Are you:
☐**Married** How long________
☐**Partner or significant other**
☐ **Single** ☐ **Divorced**

Gender:
☐ Male ☐ Female
☐ Transgender ☐ Transsexual
☐ Decline to state

Sexual Orientation:
☐ Heterosexual
☐ Homosexual
☐ Bisexual
☐ Other _______________

Do you have children?
Yes ☐ No ☐
How old are they?
___ ___ ___ ___ ___
Whom do they live with?
____
Do you see them and how often?
____

Employment:
☐ Employed: Occupation____________________ Years?____
☐ Student (Where?) _____________________________
☐ Volunteer ☐Retired ☐Unemployed
☐Disabled ☐Worker's Comp

Who raised you?
☐ Parents ☐ Other _____________________________________
How many siblings do you have? _______
Living situation: ☐Rent ☐ Own
☐Apartment ☐Condo ☐House ☐Shelter Institution
☐Homeless ☐Other _________________
Whom do you live with?_____________________________
Do they approve of your marijuana use? Yes ☐ No ☐

Have you ever experienced or been diagnosed with any of the following? (enter age or year diagnosed)
☐ ADD ____ ☐ Physical Abuse ____
☐ ADHD ____ ☐ Emotional Abuse ____
☐ School problems ____ ☐ Sexual Abuse ____
☐ Depression ____ ☐ Suicidal Thoughts ____
☐ Behavior issues ____ ☐ N/A
What medications (if any) did you take? and when?
____

Additional Health Information

Please write any other information that would be useful for the doctor:

____
____
____
____
____

FOR STAFF USE ONLY **Last Name**_____________________ **First Name**_____________________

B/P	Pulse	HT	WT	LNMP	G P
	☐ **Normal organ system**				**Abnormal findings**

General:	☐ well developed/well nourished – alert
Skin:	☐ intact…warm…dry…well hydrated…no rashes
HEENT:	☐ External inspection nml…
Neck:	☐ Non-tender – ROM w/o pain – no palpable masses
Resp:	☐ nml resp. effort & excursion – breath sounds nml/equal/clear
CVS/chest:	☐ RRR – no M/G/R – nml s1/s2
GI:	☐ non distended – non-tender – no masses – no guarding – no rebound
Back:	☐ no vertebral tenderness – no CVAT
Hips/Pelvis:	☐ FROM … non-tender
Extremities:	☐ FROM …normal extremities:
Neuro:	☐ CN II-XII intact…DTR's symmetric…sensory nml…motor symmetric/ wnl…leg raise neg.
Psych/Mini Mental status:	☐ oriented x 3…mood appropriate…judgment good…nonsuicidal Done if needed: Date, place, register 3 Objects, Serial Sevens, Recall 3 Objects, etc.
Notes	____________________
Assessment	____________________
Plan	____________________

☐ Pt. to f/u with PMD for management, update of mental/physical conditions.
☐ Vaporizer/edibles etc. ☐ R&B discussed ☐ Medical Record release

Cannabis approval for:

☐ 2 months ☐ 3 months ☐ 6 months ☐ 1 Year ☐Other ______/______/_______

Diagnosis: ____

Comments: ____

Physician's Signature ______________________________ **Date**_________________