OFFICE USE ONLY

POS _____ Survey _____

Notes _____

Bud & Mary's Dispensary – Patient Intake Form

Patient Registration #: _____ Active Duty/Veteran: ☐ Yes ☐ No

DOB: _____ Today's Date: _____

Patient Contact Information

Name: _____ Preferred name: _____

Address: _____

City/State/ZIP: _____

Phone (Main): _____ Phone (Alt): _____

Email: _____

Certifying Doctor

Provider Name: _____

Cannabis Caregiver Contact Information (must be registered with the state)

Name: _____

Address: _____

City/State/ZIP: _____

Phone: _____ Email: _____

How Did you hear about us?

☐ Friends/Family ☐ Website
☐ News Outlet ☐ Medical Professional
☐ Social Media ☐ Event

Were you referred by an existing patient?

If so, please list their name here:

_____

MEDICAL HISTORY

1. For which condition(s) has the patient received a certification for medical cannabis?

Please check all that apply.

☐ Amyotrophic lateral sclerosis (ALS)
☐ Parkinson's disease (PD)
☐ Cancer
☐ Seizures
☐ Crohn's disease
☐ HIV/AIDS
☐ Ulcerative colitis
☐ Multiple sclerosis (MS)
☐ Autism
☐ Intellectual Disability
☐ Post-Traumatic Stress Disorder
☐ Corticobasal Degeneration
☐ Chronic pain
☐ Terminal illness

2. Rate the severity of your symptoms. Please indicate the severity of the patient's symptoms using a scale of 1 through 10. (1 = not interfering with life at all and 10 = substantially interfering with life). Check all that apply.

Select (x)	Symptom	Severity (1-10)	Select (x)	Symptom	Severity (1-10)
	Chronic pain			Muscle spasticity	
	- Gastrointestinal pain			Tremors	
	- Neuropathy			Insomnia	
	- Arthritis			Seizures	
	Lack of appetite			Anxiety	
	Nausea and/or vomiting			Self injurious behavior	
	Muscle spasms			Other:	

ADDITIONAL QUESTIONS

	YES	NO	N/A OR UNKNOWN
Does the patient have a heart condition or heart disease?			
Is the patient currently pregnant, think they may be pregnant, or planning to become pregnant?			
Are you on any of the following medications? Clobazam, Valproate, Warfarin			
Severe adverse event or medication sensitive?			

Please list **ALL relevant prescriptions**.

PRODUCT	DOSE	FREQUENCY	CONDITION BEING TREATED

What is your current quality of health **BEFORE** cannabis treatment?

☐ Very Bad ☐ Bad ☐ Neither Good nor Bad ☐ Good ☐ Very Good

CANNABIS HISTORY

Patient's level of experience with cannabis:

☐ No Experience ☐ Some Experience ☐ Experienced