Patient Initial Form

Name_____Date_____

Age _____ Date of Birth_____/_____/_____ Marital Status_____ Sex: Male / Female

Address: _____ City_____ State_____ Zip_____

Phone_____ (Circle: home/work/cell) E-mail_____

Are you on probation or parole? Yes or No

What is your occupation?

_____

How did you hear about us? _____

Which treatments have you tried to treat your problems? *Circle all that apply*

Surgery Counseling Physical Therapy Chiropractic Care Acupuncture

Homeopathy None Other

_____

Have you ever been admitted in the hospital? Yes/No If Yes, give details and Dates:

_____

_____

Are you taking any prescription medications? Yes/No If yes, please list _____

_____

Do you have any allergies to medications? Yes/No If yes, please identify

_____

Do you smoke tobacco? Yes / No Do you drink alcohol? Yes / No Are you pregnant? Yes / No

Do you currently use cannabis (marijuana) for your medical condition? Yes / No / Tried It

How does cannabis compare with other medication that you take for your medical problem?

_____

Have you ever been exposed to asbestos, chemicals, poisons, or radiation (besides X-rays) Yes / No

Are there health/medical problems that occur frequently in your family? Yes / No

If yes, please explain: _____

Medical conditions: (**Check box that apply)** Do you have problems with:

☐ Arthritis	☐ Heart Disease
☐ Autoimmune disease	☐ High blood pressure
☐ Back and neck pain	☐ HIV / AIDS
☐ Brain disorder	☐ Hyperhidrosis **(Sweaty palms, feet, etc.)**
☐ Breast lesions	☐ Gastrointestinal disorders **(Ulcers, Colitis, Crohns, IBS, GERD, Diverticilitis, etc.)**
☐ Cancer specify:	☐ Kidney disease **(Renal failure, stone, etc.)**
☐ Chronic pain, specify:	☐ Liver disease **(Cirrhosis, Hepatitis B or C, etc.)**
☐ Diabetes	☐ Lung disease **(Asthma, Emphysema, etc.)**
☐ Dystonia **(Tremors, Parkinsons, etc.)**	☐ Menstrual disorders **(cramps, Menopausal syndrome, etc.)**
☐ Ear problems	☐ Migraine headaches
☐ Eating disorder **(Anorexia, Bulimia, nausea)**	☐ Multiple sclerosis **(Neurodegenerative disease)**
☐ Endocrine problems **(Thyroid, Hormones)**	☐ Neuropathy, Restlessleg syndrome
☐ Eye problems **(Glaucoma, Cataracts, blindness, etc.)**	☐ Psychological **(Depression, Anxiety, ADHD, PTSD, Bipolar disorder, Schizophrenia)**
☐ Fibromyalgia	☐ Skin disorder **(Psoriasis, Eczema)**
☐ Urogenital/ GYN problems/ overactive bladder/ enlarged prostate	☐ Sleep disorder
☐ Gout	☐ Substance abuse **(tobacco, alcohol, etc.)**
☐ Other	☐ Weight loss/gain

DISCLOSURES AND CONDITIONS

1. **"SB Medical Evaluation" (California Inc.) provides medical evaluations and consultations regarding recommendations for medical cannabis (medical marijuana) only.**
2. **Services for which fees may be collected include: medical consultation and evaluations, copying or duplication of medical records.**
3. **Payment of fees does not entitle, ensure, or warrant that (1) Patient will receive a medical cannabis recommendation (2) Any recommendation given will be written for at least twelve months.**
4. **Indications for medicinal use of cannabis include but are not limited to: cancer, aids, glaucoma, chronic nausea, headaches, arthritis, multiple sclerosis, seizures, anorexia, severe or chronic pain, anxiety, depression, menstrual cramps, chronic insomnia and IBS.**
5. **All evaluations are done by a California licensed physician and include (1) Taking medical history, (2) Review of patients prior medical records. All prospective patients should bring their medical records and any prior or currently taken prescribed medications.**
6. **"SB Medical Evaluation" does not provide primary care, medication prescriptions, or other treatments. The physician may refer the patient to other providers and outside medical care for further evaluation and treatment.**
7. **Subsequent to SB Medical Evaluation, all patients are instructed to follow-up with their own primary care physicians, mental health and other health care providers and outside medical care for continuing care. Likewise, where recommendation is given, physician may require appropriate follow up be made.**
8. **All patients using medical cannabis are advised against driving, operating heavy machinery or equipment under the influence of cannabis.**
9. **Side effects associated with medical marijuana use include: dry mouth; headache; nausea; tremor; nystagumus; rapid heart rate; reduced muscle strength; decreased blood flow to the brain; decreased coordination; decreased lung capacity/bronchoconstriction; increased appetite and possible weight gain; altered body temperature; anxiety or panic; paranoia; confusion; aggressiveness; hallucinations; suicidal ideation; sedation; altered libido; alternation in time, space and color perception; depersonalization; short-term memory impairment; addictive behaviors; decreased verbal skills; amotivational syndrome; reduced testicular size; decreased testosterone levels; menstrual abnormalities; impotence; abnormal sperm morphology/ motility; infertility; gynecomastia; abnormal olva; fetal exposure (in pregnant users)**
10. **No transportation or mailing medical marijuana out of state and no carrying of medical marijuana while traveling out of state of California.**

I hereby certify that I have read and acknowledge all of the above. Please initial _____

MEDICAL MARIJUANA ACKNOWLEDGEMENT OF DISCLOSURE AND INFORMED CONSENT

Read each item below to indicate that you understand and agree to each item. Do not sign this agreement and do not use medical marijuana if you have questions about or do not understand the information you have received.

I understand that medical marijuana is a medicine used in treating suffering caused by serious and debilitating medical conditions. Serious and debilitating conditions include:

1. **Acquired immune deficiency syndrome (AIDS)**
2. **Anorexia**
3. **Arthritis**
4. **Cachexia**
5. **Cancer**
6. **Chronis Pain**
7. **Glaucoma**
8. **Migraine**
9. **Muscle Spasms**
10. **Seizures**
11. **Any other chronic or persistent medical symptom that either:**
    a.) **Substantially limits the ability of the person top conduct on or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336)**
    b.) **If not alleviated, may cause serious harm to the patient's safety or physical health.**

I understand that medical marijuana use for treatment of these conditions has NOT been approved by the Federal Drug Association (FDA).

I have been advised that the use of cannabis (medical marijuana) may affect my coordination and cognition in ways that could impair my ability to drive, operate heavy machinery, or engage in potentially hazardous activities.

Although smoking marijuana has not been linked to lung cancer, smoking marijuana can cause respiratory harm, such as bronchitis. Many researchers agree that marijuana smoke contains carcinogens (chemicals that can cause cancer) and that smoking marijuana may increase the risk of respiratory diseases and cancers of the lungs, mouth, and tongue. I have been advised that cannabis (medical marijuana) smoke contains chemicals known are tarts that may be harmful to my health. Vaporizers may substantially reduce many of the potentially harmful smoke toxins that are normally present in marijuana smoke.

Marijuana varies in potency. The effects of marijuana can also vary with the delivery system. Estimating the proper marijuana dosage is very important. Symptoms of marijuana overdose include, but are not limited to:

1. **Nausea**
2. **Vomiting**
3. **Disturbances to heart and numbness of the limbs**
4. **Hacking cough**

For some patients chronic marijuana over use can lead to laryngitis, bronchitis, and general apathy.

Using marijuana may decrease reproduction function in men as well as women. Women who are trying to conceive, or who are pregnant or breast-feeding should not use marijuana. Marijuana may increase risk of leukemia in children whose mothers smoked marijuana during pregnancy.

I understand as a patient that it is possible to become dependent on marijuana. This means experiencing withdrawal symptoms when the use of cannabis (medical marijuana) has been stopped. Signs of withdrawal symptoms, while generally mild, can include:

1. **Feelings of depression, sadness or irritability**
2. **Trouble concentrating**
3. **Loss of appetite**
4. **Sleep Disturbances**
5. **Unusual tiredness**

Although marijuana does not produce a specific psychosis, the possibility exists that is may exacerbate schizophrenia in persons predisposed to said disorder.

I understand that using marijuana while under the influence of alcohol is not recommended. I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities and/or contaminants.

I certify and declare under penalty of perjury that I have read and understand the information contained herein, and the information I have given is true, correct and complete.

MEDICAL MARIJUANA PATIENT AGREEMENT

I <u>agree</u> to tell the attending physician if I have ever had symptoms of depression, been psychotic, attempted suicide, or had any other mental problem. I also agree to tell the attending physician if I ever have been prescribed or taken medicine for any of these problems.

I understand that the attending physician does not condone that I cease treatment of medications that stabilize my mental or physical condition.

I affirm that I have a serious medical condition that adversely affects my quality of life. I have found or am interested in finding whether cannabis (medical marijuana) provides substantial relief and improvement in my condition.

If I start taking medical marijuana, I agree to tell my attending physician if I experience any adverse symptoms (side effects), including but not limited to

1. **Start to feel sad or have crying spell**
2. **Have changes in my normal patterns activities**
3. **Loss of appetite**
4. **Become more irritable than usual**
5. **Become unusually tired**
6. **Loss of interest in usual**

I understand that the cannabis plant is not regulated by the U.S Food and Drug Administration and may contain unknown qualities of active ingredients, impurities and or contaminants. In requesting and approval or recommendation for the use of this plant as medication I assume full

responsibility for any and all risks of this action. Also, I am advised that the use of cannabis may affect my coordination and condition in ways that could impair my ability to drive, operate heavy machinery, or engage in potentially hazardous events. I assume for any harm resulting to me and/or individuals as a result of my use of cannabis.

Some users develop a tolerance to marijuana. This means higher and doses are required to achieve the same pain relief. If I think I may be developing a tolerance to marijuana, I will notify my attending physician. Should respiratory problems or other ill effects be experienced in association with the use of medical marijuana I agree to discontinue its use and report such problems or effects to my attending physician.

I understand that the attending physician, staff, and representative of this practice are neither providing nor dispensing cannabis, nor are they encouraging any illegal activity obtaining medical marijuana.

I understand and that the attending physician, in order to conduct an appropriate evaluation, must do a physical exam and take my prior medical history and family history. I decline examination of my private parts unless it is relevant to my complaints.

At this time, cannabis is an alternative or complementary treatment. I understand to receive a recommendation for cannabis use, I should try, or be willing to consider trying at least one other recommended treatment for a medical provider. I agree to be referred for further evaluation as the physician deems necessary.

RELEASE OF ALL CLAIMS AND LIABILITY

I, the undersigned, hereby request a consultation by a physician for the sole purposes of determining the appropriateness of medical cannabis treatment.

I, the undersigned understand that there is no representatives of addressing specific aspects of my medical care and, unless otherwise stated are in no way establishing themselves as my primary care provider. The physician is only rendering an opinion regarding the therapeutic recommendation indicating use of medical marijuana.

I, the undersigned, further understand that should I be given a recommendation for medical use of cannabis; I understand that I must be regularly followed-up by my primary care physician, and appear for a re-evaluation at a date specified by the physician.

Furthermore, the undersigned, my heirs, assigns, or any acting on my behalf, hold the physician and his/her principles, agents and employees, free of responsibility and liability resulting from the use of cannabis. In case of any claim or dispute arise, I agree to arbitrate such claims/disputes and I agree

that California law will govern such claims/disputes. Further, if any of these clauses is deemed invalid, the other clauses will remain in full force and effect.

Patient Name _____ Patient Signature _____

Date _____