MEDICAL MARIJUANA PRESCRIBER NP

PATIENT INTAKE FORM

Please complete this form and email the following to MedicalMarijuanaPrescriberNP@gmail.com

- Completed intake form
- Copy of your NY State Driver's License or Non-Driver ID
- Copy of any pertinent medical records pertaining to your qualifying condition

The consultation fee is $100. We accept credit cards, debit cards or PayPal.

Date:	
Name:	
Date of birth:	
Street:	
City:	
State:	
Zip/Postal Code:	
Email:	
Cell Phone:	
Home Phone:	
Emergency Contact:	
Emergency Contact Phone:	
Emergency Contact Email:	
Relationship:	
PCP Name:	
PCP Address:	
PCP Phone:	

PCP Fax:	
Do You Have A NY Driver's License?	☐ Yes ☐ No
Do you have a copy of medical documentation supporting your qualified condition?	☐ Yes ☐ No
Reason for seeking medical marijuana:	☐ Chronic Pain: Location of pain:_____ ☐ P.T.S.D. (Post-Traumatic Stress Disorder), (anxiety, depression, insomnia, panic attacks) ☐ Pain that degrades health and functional capacity where the use of medical marijuana is an alternative to opioid use. ☐ Opioid Use Disorder/Substance Use Disorder (Prescriber must have a data 2000 waiver) ☐ Neuropathy/Radiculopathy ☐ Epilepsy/Seizure Disorder ☐ Cancer: What type of cancer:_____ ☐ HIV+ ☐ AIDS ☐ A.L.S./Amyotrophic Lateral Sclerosis/Lou Gehrig's Disease ☐ Parkinson's Disease ☐ Multiple Sclerosis ☐ Damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity ☐ I.B.D./Inflammatory Bowel Disease ☐ Huntington's Disease
Associated Symptoms:	☐ PTSD ☐ Opioid Use Disorder (must be in an Article 32 Treatment program) ☐ Seizures ☐ Severe Nausea ☐ Severe or persistent muscle spasms ☐ Severe of chronic pain resulting in substantial limitation of function ☐ Cachexia or wasting syndrome
CURRENT/PREVIOUS TREATMENTS:	☐ Chiropractor ☐ Yoga ☐ Acupuncture

	☐ Meditation ☐ Stretching ☐ Vitamins ☐ Exercise ☐ Counseling ☐ Massage Therapy ☐ Physical Therapy ☐ Injections ☐ Other:_____
Chief Complaint:	
History If Present Illness:	
Past Psychiatric History:	
Trauma History:	
Family Psychiatric History:	
Past Medical History:	
Past Surgical History:	
Hospitalizations:	
Medications:	
Allergies:	
Tobacco Use:	
Alcohol Use:	
Cannabis Use:	
Substance Abuse:	
Social History:	
Educational/Occupational History:	
Legal History:	

Additional Information:	