

# MMJ PATIENT INTAKE FORM

Please complete this form and fax to 917-522-9678 or email to [420CardNYC@gmail.com](mailto:420CardNYC@gmail.com). Please include copy of you NY State Driver's License or Non-Driver ID and copy of any pertinent medical records pertaining to your qualifying condition.

The consultation fee is \$150. I accept credit cards, debit cards, PayPal, Venmo & Zelle.

<b>Date:</b>	
<b>Name:</b>	
<b>Date of Birth:</b>	
<b>Street:</b>	
<b>City:</b>	
<b>State:</b>	
<b>Zip/Postal Code:</b>	
<b>Email:</b>	
<b>Cell Phone:</b>	
<b>Home Phone:</b>	
<b>Emergency Contact:</b>	
<b>Emergency Contact Phone:</b>	
<b>Emergency Contact Email:</b>	
<b>Relationship:</b>	
<b>PCP Name:</b>	
<b>PCP Address:</b>	
<b>PCP Phone:</b>	
<b>PCP Fax:</b>	
<b>Do You Have A NY Driver's License or non-driver ID?</b>	

<p><b>Do you have a copy of medical documentation supporting your qualified condition?</b></p>	
<p><b>What is your primary reason for needing medical marijuana?</b></p>	<p> <input type="checkbox"/> Chronic Pain  <input type="checkbox"/> P.T.S.D.  <input type="checkbox"/> Anxiety  <input type="checkbox"/> Depression  <input type="checkbox"/> Insomnia  <input type="checkbox"/> Panic attacks  <input type="checkbox"/> Opioid Use Disorder/Substance Use Disorder  <input type="checkbox"/> Neuropathy/Radiculopathy  <input type="checkbox"/> Epilepsy/Seizure Disorder  <input type="checkbox"/> Cancer  <input type="checkbox"/> Migraines  <input type="checkbox"/> Dysmenorrhea (Severe menstrual cramps)  <input type="checkbox"/> HIV+ or AIDS  <input type="checkbox"/> A.L.S./Amyotrophic Lateral Sclerosis/Lou Gehrig's Disease  <input type="checkbox"/> Parkinson's Disease  <input type="checkbox"/> Multiple Sclerosis  <input type="checkbox"/> I.B.D./Inflammatory Bowel Disease  <input type="checkbox"/> Huntington's Disease  <input type="checkbox"/> Other _____ </p>
<p><b>Please explain your current condition &amp; symptoms that you are having:</b></p>	
<p><b>List current or past Psychiatric conditions:</b></p>	
<p><b>List any traumatic injuries:</b></p>	
<p><b>List current and past medical conditions:</b></p>	
<p><b>List dates and type of surgeries that you've had:</b></p>	

<b>List dates and reason for hospitalizations:</b>	
<b>List your medications:</b>	
<b>List your allergies:</b>	
<b>Do you use tobacco? If yes, how much?</b>	
<b>Do you drink alcohol? How much?</b>	
<b>Do you use Cannabis? If yes, which type?</b>	
<b>Do you have a history of substance abuse? Type?</b>	
<b>Are you currently employed?</b>	
<b>What is your current profession?</b>	
<b>Do you get drug tested at work?</b>	
<b>Have you ever had a DWI?</b>	
<b>Have you ever been arrested for a drug related crime?</b>	
<b>Are you currently on Parole or Probation?</b>	
<b>Additional Information:</b>	

## **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 laws of New York State, a medical marijuana recommendation from a physician must be fully valid and that I must abide by the possession and usage requirements outlined by my respective State law.

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 this practice to confirm the following identifying information: name, date(s) seen, date of birth, date of expiration, and diagnose(s).

### **RELEASE OF LIABILITY**

The physician, staff, and representatives of this practice 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.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_