The Holistic Center

Patient Information

Name: ____ Date:____________________
LAST FIRST MIDDLE

Age: _____ Gender: ☐Male ☐Female Date of Birth: ____________

Address: ______________________________ City: _____________ State:_____ Zip:_________

Phone: ____________________ Last 4 SS#: _______________

MA LICENSE #: _________________________ MA LICENSE EXPIRATION: __________

Mother's Maiden (Unmarried) Name: _______________________

Email:____

How did you hear about us?

☐Google ☐Newspaper ☐Yahoo ☐Craigslist ☐Friend

☐Other:____

Your Primary Care Physician Information:

Name:____

Address: ______________________________ City:_____________ State:_____ Zip:__________

Phone:____________________ Fax:_____________________

Chief Complaint:

Please describe the medical condition or compliant for which you are seeking a recommendation for medical marijuana. Please include the date of onset of your symptoms and when you received your initial diagnosis

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Does this medical condition limit your ability to conduct everyday activities? (work, eat, sleep, social interaction) Please describe:

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Do you feel that if your medical condition is not alleviated, that it could cause serious harm to your safety, physical or mental health? ☐ Yes ☐ No

Have you received medical care or been evaluated by a physician for this medical condition?

☐ Yes ☐ No

If yes, please provide the name, address, and date last seen by the physician (including a chiropractor or acupuncturist) that diagnosed and/or treated you for this medical condition.

If not listed above, please describe all treatments that you have received to date for your current medical problems such as the medications prescribed, surgeries, physical therapy, acupuncture, homeopathy, chiropractic care or other care:

Cannabis (Marijuana) History:

Do you currently use cannabis to treat your current medical condition? ☐ Yes ☐ No

At what age did you discover that cannabis eased your medical symptoms? ________

Does cannabis provide relief for your symptoms? If yes please describe what relief it provides.

How often do you use marijuana? ☐ Daily ☐ Weekly ☐ Monthly ☐ ___________

How much cannabis do you use per treatment? ____________________________

What method do you currently use to consume the cannabis?

☐ Vaporize ☐ Ingest ☐ Smoke ☐ Anointing oil

Legal History:

Are you currently on probation or parole? ☐ Yes ☐ No

Do you have a pending cannabis case? ☐ Yes ☐ No

Are you on disability? ☐ Yes ☐ No

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Past Medical History:

Please check off any of the medical conditions listed below that a physician has evaluated you for, you have been admitted to a hospital for or are currently being treated for:

☐ Cancer
☐ Glaucoma
☐ Positive status for HIV (Human Immunodeficiency Virus)
☐ AIDS (Acquired Immune Deficiency Syndrome)
☐ Hepatitis C
☐ Amyotrophic Lateral Sclerosis
☐ Crohn's disease
☐ Parkinson's disease
☐ Multiple Sclerosis (MS)
☐ Post-traumatic stress disorder
☐ Severe Chronic pain condition
☐ Severe Nausea
☐ Excessive weight Loss condition (Cachexia/Wasting Syndrome/Anorexia)
☐ Excessive weakness
☐ Impaired strength or ability progressing to one or more major life activities limitation
☐ Other debilitating conditions

Review of Symptoms:

General
☐ Fatigue
☐ Dizziness
☐ Loss of sleep/Insomnia
☐ Loss of weight
☐ Nervousness
☐ Poor energy

Cardiovascular
☐ Cardiac palpitations
☐ High blood pressure
☐ Rapid heart beat
☐ Irregular heart beat
☐ Chest pain

Neurological
☐ Fainting
☐ Migraine/Headache
☐ Seizures
☐ Stroke
☐ Vertigo
☐ Tremors
☐ Muscle Spasm

Gastrointestinal
☐ Abdominal pain or cramps
☐ Poor appetite
☐ Nausea
☐ Vomiting
☐ Constipation
☐ Diarrhea
☐ Heartburn

Psychiatric
☐ Anxiety
☐ Depression
☐ Disturbing feelings
☐ Panic attacks
☐ Restlessness

Respiratory
☐ Cough
☐ Cold
☐ Excessive Sputum/Phlegm
☐ Shortness of Breath
☐ Wheezing
☐ Snoring
☐ Obstructive Sleep Apnea

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Endocrinology
- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Excessive Sweating
- ☐ Excessive Thirst

Genitourinary
- ☐ Burning while urinating
- ☐ Difficulty urinating
- ☐ Urinary Incontinence
- ☐ Bladder/Kidney Infection
- ☐ Restlessness

Dermatology
- ☐ Rash
- ☐ Itching

Muscle/Bone/Joints

☐ Back Pain	☐ Neck Pain	☐ Shoulder Pain	☐ Hand/wrist Pain
☐ Leg Pain	☐ Arm Pain	☐ Hip Pain	☐ Ankle/Feet Pain
☐ Arthritis	☐ Muscle Cramps	☐ Knee Pain	
☐ Numbness in the arm		☐ Numbness in the leg	

Pain Intensity: Please mark your pain level at the present time (if Applicable).

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No pain				*Moderate*					*Severe*

Psychological

During the past month have you been tense or anxious? (Please circle one)

Never Seldom Sometimes Frequently Always

During the past month have you been depressed or discouraged? (Please circle one)

Never Seldom Sometimes Frequently Always

During the past month have you been irritable or upset? (Please circle one)

Never Seldom Sometimes Frequently Always

Social History

Smoking	☐ Yes	☐ No	☐ quit (How long ago?) ______________________	
Alcohol	☐ Yes	☐ No	☐ Social use	☐ daily (How much?) _______
Illicit Drugs	☐ Yes	☐ No	☐ quit (How long ago?) ______________________	

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Activities of daily life

During the past month, how much did your condition interfere with the following activities?
(Circle the number for each question)

Activity	Not at all	A little bit	Moderately	Quite a bit	Extremely
Going to work	1	2	3	4	5
Performing household chores	1	2	3	4	5
Yard work or shopping	1	2	3	4	5
Socializing with friends	1	2	3	4	5
Recreation and hobbies	1	2	3	4	5
Having sexual relations	1	2	3	4	5
Physical exercise	1	2	3	4	5
Sleep	1	2	3	4	5
Appetite	1	2	3	4	5
Ambulating	1	2	3	4	5
Toileting	1	2	3	4	5
Dressing	1	2	3	4	5
Other:	1	2	3	4	5

Current Medications (please list or state SEE MEDICAL RECORDS):

Allergies:

Patient Signature: ______________________________ Date_________________