PATIENT INTAKE QUESTIONAIRE

Name:

DOB:

Address:

City: State:

Zip code:

Driver's License #:

Height: Weight:

SSN:

Mobile:

Home phone:

E-mail address:

Primary Care Physician: Phone:

Reason for cannabis treatment (all that apply):

(Chronic pain) (Seizures) (Cancer) (Glaucoma) (Crohn's Disease)
(HIV/AIDS)

(PTSD) (ALS) (Parkinson's Disease) (Multiple Sclerosis) (Terminal illness)

Other illnesses (explain):

Relevant to your present complaints, please list all treatments you've tried, how long was each treatment
attempted, and outcomes of each treatment:

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Do you smoke cigarettes?   Y / N

Number of cigarettes smoked per day:

Number of years of cigarette use:

Do you drink alcohol?   Y / N

How many drinks per day:

Have you used illegal drugs? Y / N

Presently? Y / N

Type:

Frequency of use:

Please list all current medications and dosage:

1.

2.

3.
4.

5.

6.

7.

8.

9.

10.

Please list all allergies and reactions:

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Please list all surgeries and dates:

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.