

# PATIENT INTAKE FORM

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

MD MMCC Patient Registry Card ID #: \_\_\_\_\_

**WOULD YOU LIKE TO RECEIVE PERIODIC PROMOTIONAL OFFERS?**

YES  NO

**PLEASE PROVIDE US WITH YOUR PHONE NUMBER/E-MAIL.**  
IF YOU CHECKED "NO" TO PROMOTIONAL OFFERS, YOU WILL ONLY BE CONTACTED FOR URGENT MATTERS REGARDING YOUR MEDICINE.

E-MAIL ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

CELL PHONE CARRIER: \_\_\_\_\_

*You are not required to complete this form, however doing so will help us better serve you and meet your needs. Your responses are considered strictly confidential. Patient information will never be disclosed to other patients, third parties, or anyone other than authorized agents of this dispensary.*

## 1. How did you hear about us?

- Referral.
- Internet. Please specify source below:
  - Google  Weedtracker  Leafly  Other (Specify): \_\_\_\_\_
- Magazine. Please specify: \_\_\_\_\_
- Media. Please specify source/channel below:
  - TV (specify channel): \_\_\_\_\_
  - Radio (specify channel): \_\_\_\_\_
  - Other (specify): \_\_\_\_\_
- Event. Please specify: \_\_\_\_\_

## 2. What made you choose this dispensary?

\_\_\_\_\_

## 3. What condition has your doctor recommended medical cannabis use for treatment?

<input type="checkbox"/> Cancer	<input type="checkbox"/> Cachexia	<input type="checkbox"/> Seizures
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> AIDS	<input type="checkbox"/> PTSD	<input type="checkbox"/> Traumatic Brain Injury
<input type="checkbox"/> Crohn's Disease		<input type="checkbox"/> Other (specify):

**4. Have you previously used medical cannabis to treat this condition?**

- No.
- Yes. If yes, did medical cannabis provide relief for your condition?
  - Yes.
  - No. If no, please identify the response that most accurately describes your situation:
    - I did not experience any relief for my condition after using medical cannabis.
    - I experienced minimal relief of my condition after using medical cannabis.
    - I experienced some relief of my condition after using medical cannabis, however I experienced undesirable psychoactive effects (i.e., anxiety, paranoia, drowsiness).

**5. What type of cannabis has been most effective in relieving your condition?**

- Sativa     Sativa-dominant hybrid     Indica-dominant hybrid     Indica     Unsure

**6. If there are specific strains that have worked well for you, please list them here:**

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**7. If applicable, please indicate which method of consumption you previously used?**

- Smoking     Vaporizing     Edible     Topical Application     First Time

**8. What is your *preferred* method of consumption?**

- Smoking     Vaporizing     Edible     Topical Application     Unsure

**9. Depending on individual needs and preferences, patients may select medical cannabis that has greater or lesser psychoactive effects. Psychoactive effects are subjective changes in perception, consciousness and mood such as euphoria, increased alertness, psychomotor coordination, concentration, and so forth. Patients may or may not desire these effects based on when and how they are using the medicine.**

Please select the response that most accurately describes the psychoactive affects you seek:

- I prefer to experience little to no psychoactive effects from my medicine.
- I prefer to experience moderate psychoactive effects from my medicine.
- I prefer to experience strong psychoactive effects from my medicine.

**10. At what time of the day do you intend to medicate?**

- Morning     Afternoon     Evening/Bedtime     Multiple Times Throughout the Day

**11. Do you intend to medicate prior to work or plan to be medicated while at work?**

- No.
- Yes. If yes, does your job require you to perform safety-sensitive duties such as operating heavy machinery?
  - No.
  - Yes. Keep in mind that medicinal cannabis with increased psychotropic effects should not be used while performing safety-sensitive duties.