KEYSTONE CANNA REMEDIES

Patient Intake Form

Last Name:_____ First Name:_____

DOB: _____/_____/_____ Sex: M / F Date of Consult_____

Address:_____

City:_____ State: __PA____ Zip:_____

Preferred Ph. # (home/cell/work):_____ Alt. Ph. #:_____

Email Address:_____

How did you hear about us? _____

Patient Caregiver #1 (if none, write n/a): _____

Caregiver #1 Contact Information:_____

Patient Caregiver #2 (if none, write n/a):_____

Caregiver #2 Contact Information:_____

Emergency Contact Name:_____

Emerg. Contact Phone # / Relation to Patient:_____

Qualifying Condition(s) for Pennsylvania MMJ Program:

- ☐ Amyotrophic Lateral Sclerosis
- ☐ Autism
- ☐ Cancer
- ☐ Crohn's Disease
- ☐ Spinal Cord Injury
- ☐ Dyskinetic/Spastic Disorder
- ☐ Epilepsy
- ☐ Anxiety
- ☐ Glaucoma
- ☐ HIV/AIDS
- ☐ Huntington's Disease
- ☐ Inflammatory Bowel Disease
- ☐ Intractable Seizures
- ☐ Multiple Sclerosis
- ☐ Neurodegenerative Diseases
- ☐ Tourette's Syndrome
- ☐ Neuropathies
- ☐ Opioid Use Disorder
- ☐ Parkinson's Disease
- ☐ PTSD
- ☐ Chronic Pain
- ☐ Sickle Cell Anemia
- ☐ Terminal Illness

PLEASE COMPLETE **ALL 4 PAGES** OF THIS FORM. THANK YOU!

Concurrent Medical Diagnoses			
DIAGNOSIS made by Health Care Provider: (make an X in front of disease (s))			
	AIDS / HIV		Arthritis of:
	ADHD (attention deficit hyperactivity disorder)		Cancer of:
	Asthma		Bipolar/Schizoaffective Disorder
	COPD		**Schizophrenia**
	Permanently disabled		Depression
	Diabetes w/ extremity pain or nausea		Migraine headaches
	Glaucoma		Stomach ulcers
	Heart disease		**Epilepsy / Seizures**
	High Blood Pressure		Amyotrophic Lateral Sclerosis (ALS)
	Stroke		Hepatitis: B or C
	Kidney disease		Multiple Sclerosis
	Muscle or Movement Disease		Parkinson's Disease
	Other:		Other:
SYMPTOMS you are experiencing: (make an X in front of symptoms)			
	Anxiety / Stress		Depressed feelings
	Pain, Joints; location:		Pain, Neck or Back
	Headaches		Muscle spasms; where:
	Vision problems/eye pain		Numbness or tingling in limbs
	Acid Reflux / Heartburn / Stomach Pain		Insomnia / Sleeping disorder
	Loss of appetite / Weight loss		Nausea / Vomiting
	Constipation (especially with medications)		Chronic Cough
	Dizziness		Urinary problems
	Skin Rash		Tremor
	Seizures/Convulsions		Other:

Do you consume Alcohol? ❑ no ❑ yes Number of drinks per week_____

Do you use Tobacco products? ❑ no ❑ yes Smoke/Chew Qty per day_____

Female patients: Are you pregnant? ❑ no ❑ yes Breastfeeding? ❑ no ❑ yes

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Are you currently taking any medications on a regular chronic basis? Check those that apply.

Prescription medication? ❑ no ❑ yes OTC medications? ❑ no ❑ yes

Herbal medications? ❑ no ❑ yes Vitamins & Minerals? ❑ no ❑ yes

Please list all medications on the next page: **KCR Medication Documentation Sheet**

KCR Medication Documentation Sheet

(please include prescription, OTC, and vitamins, & herbal medications you are **currently taking**)

Medication Name	Medication Name

Allergies (food, medication, ingredients, other):_____

_____

_____

History of Marijuana Use (please circle): Never Used | Used in Past | Currently Using

Describe Use (please circle): Mostly Medical | Mostly Recreational | Both Med and Rec

Used approximately how long?_____

Dosage Forms Used:

☐ Smoked Flower	☐ Edible Products	☐ Tinctures	☐ Other (please list below)
☐ Vaporized Flower	☐ Capsules/Tablets	☐ Sublingual Sprays	
☐ Vaporized Oil	☐ Liquids/Drinks	☐ Transdermal Patches	
☐ Concentrates	☐ Homemade Edibles	☐ Lotions/Topicals	_____

History of Adverse Reactions to Marijuana?_____

Did your physician place restrictions on your MMJ?_____

Goals of Therapy with MMJ:_____

_____

Any special needs required by patient?_____

_____

_____

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Thank you for your information.
Please note, this information will NOT be shared with other parties without patient consent.

We look forward to providing you with safe access to Pennsylvania Medical Marijuana.