



Consult Y / N

Previous Dispensary Consult: _____

MMJ Patient ID: _____

Location: _____

Reviewed by: _____

Restrictions: _____

New Patient Intake Form

DEMOGRAPHIC INFORMATION

Today's Date: _____

Patient Name: _____ Date of Birth: ____/____/____
(First) (Last) (MM) (DD) (YYYY)

Address: _____ Phone Number: _____
(Street)

(City) (State) (Zip) Email: _____

IF APPLICABLE

PA Department of Health Certified Caregiver Name: _____

Caregiver Relationship to Patient: _____ Caregiver Phone: _____

How did you hear about us? Friend/Family Web Search Physician Social Media Leafly/Weedmaps
 Event (which event) _____

MARIJUANA CERTIFICATION

Medical Marijuana Card Issue Date: ____/____/____ Expiration Date: ____/____/____
(MM) (DD) (YYYY) (MM) (DD) (YYYY)

Name of Certifying Physician: _____

Qualifying Condition(s) for Pennsylvania MMJ Program:

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

MEDICATIONS

Are you currently taking any prescription, over the counter, vitamins and/or herbal medications?

yes (see below) no

Medication Documentation Sheet

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

MEDICATION NAME	STRENGTH	HOW OFTEN	REASON FOR TAKING

Any allergies (medications, food and/or ingredients)? yes no

If "YES", please provide information: _____

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

SOCIAL HISTORY

Do you consume Alcohol? yes no Number of drinks per week _____

Do you use Tobacco products? yes no Smoke/Chew Qty per day _____

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

If currently using, how often? _____ per month _____ per week _____ per day

Dosage Forms Used:

Inhaled Ingested Lotions/Topicals Other _____

History of Adverse Reactions to Marijuana? yes (see below) no N/A

Paranoia Sedation Anxiety Increase heart rate/palpitation Increase appetite

Other _____

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.

Medical Diagnoses	
CNS	GI
Epilepsy/Seizures	Stomach ulcers/GERD
Muscle or Movement disease	Crohn's/IBS
Amyotrophic Lateral Sclerosis (ALS)	Respiratory
Parkinson's disease	Asthma
Multiple Sclerosis (MS)	COPD/Emphysema/other respiratory issues
Autism	Other
Psych	Arthritis
Anxiety	Migraine/Headache
Depression	Post-Op Pain
Bipolar	Thyroid disease
ADD/ADHD	Diabetes
Substance abuse	Kidney disease
Sleep disorder	Glaucoma
Mood disorder	Hepatitis B or C
Schizophrenia	HIV/AIDS
Cardiovascular	Cancer
Hypertension (HBP)	Walks with assistance
Dysrhythmia/AFib/Arrhythmia	Wheelchair-bound
Stroke	Permanently disabled
Pacemaker	Homebound
Heart disease/Cardiac issues	Other
SYMPTOMS being experienced	
Acid reflux/Heartburn/Stomach pain	Nausea/Vomiting
Anxiety/Stress/Panic Attacks	Constipation
Dementia	Migraine/Headache
Depressed feelings	Inflammation
Insomnia	Neuropathy/Nerve pain
Trouble Falling or staying asleep	Sciatica
Memory issues/concerns	Pain, joints
Eye pain/Vision problems	Pain, neck/back
Fatigue	Muscle spasm/pain
Dizziness	Pain, extremities
Loss of appetite/Weight loss	Other