THE APOTHECARIUM DISPENSARY

KEYSTONE CANNA REMEDIES

For Office Use Only:

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)

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

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:

- ☐ 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

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/Arrythmia		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

THE
APOTHECARIUM
DISPENSARY

Please INITIAL next to each statement then sign and date the bottom of this form.

_____I understand that I can only purchase medical marijuana product with a valid Pennsylvania Medical Marijuana Card and valid certification in place.

_____I understand, acknowledge, and confirm that the cannabis plant is not regulated by the Food and Drug Administration and is listed as a Schedule I Controlled substance with the U.S. Drug Enforcement Agency. I understand, acknowledge and affirm that it is unlawful for anyone other than a patient/caregiver with a valid medical marijuana card to possess or use medical marijuana products. I understand and acknowledge that it is illegal to divert, transfer, sell, or give any medical marijuana product purchased to anyone other than the patient/caregiver to whom it was dispensed.

_____I understand, acknowledge, and affirm that it is unlawful for any person under the age of 18 to obtain or use medical marijuana products unless they are a patient. I agree to keep all medical marijuana products out of reach of children, other than when a caregiver is administering to a patient.

_____I understand that medical marijuana contains psychoactive ingredients that may affect my coordination, motor skills, and cognition in ways that could impair my ability to drive, operate heavy machinery, or engage in potentially hazardous activity. I understand that there are side effects associated with using medical marijuana and have discussed the risks of medical marijuana with my approved certifying physician.

_____I agree not to open or use purchased medical marijuana products within 1000 feet of Apothecarium dispensary facility or any other place as prohibited by law. I understand it is recommended to use my medical marijuana product within the privacy of my own home.

_____I consent to receive email communication form The Apothecarium Dispensary. I understand I can opt out of dispensary communications by clicking "unsubscribe" on any individual email.

_____ _____

SIGNATURE OF PATIENT OR CAREGIVER DATE

☐ I have been given a copy of this form.