REFERRED BY:_____ LENGTH OF REC: full year 3mon 6 mon RENEW first
(E-LOCAL, IEW, MCC Dir, NORML, POSTCARD GOOGLE etc)

Patient Intake Questionnaire

Filling out this form does not guarantee an approval or recommendation for the use of medicinal cannabis.

Name _____ Date _____
First **Middle** **Last**

Address _____
Street City State Zip
Telephone _____ email _____text #_____
can we contact you by email? Yes____no____ may we text you? Yes_____ no_____text #_____
Age _____ Occupation _____

Current Medical Complaint _____

Are you currently under the care of a physician? Yes _____ No _____
If yes, what is the name of your primary care physician? _____
Physician's Address_____Telephone_____
If no, please provide us with the name of the physician or medical facility that you visited for your medical condition(s) _____
Did you bring medical records/documentation today? Yes___ No___
If yes, what did you bring? _____
Have you been evaluated for the use of medical marijuana by any other physician in the past? Yes ___ No ___
If yes, please give name of doctor, date seen and condition for which cannabis was approved
_____
Have you been evaluated and denied a medical marijuana recommendation? Yes ___ No ___
If yes, please explain _____

Are you currently enrolled or attending school? Yes___ No ___ **If yes,** please specify HS___ College___ Other___
Do you have children? Yes___ No ___ **If yes,** what are your children's ages? _____
Female Patients: Are you pregnant? Yes ___ No ___Are you planning a pregnancy? Yes ___ No___
Have you been arrested or charged with a crime in the last 2 years? Yes ___ No ___ **If yes,** please specify
_____

Are you currently on parole/probation? Yes ___ No ___
Are you currently attending or have you attended any drug/substance abuse or rehabilitation program?
If yes, what was name of program? _____
Date entered _____
What was your reason for entering the program? _____
Have you ever been treated for symptoms of depression, been psychotic, attempted suicide or had any other mental problems? Yes ___ No___
If yes, explain _____
Have you ever been prescribed or taken medication for any of these problems? Yes ___ No___
If yes, what medications _____
If applicable, what is the name of your mental health physician _____

Do you currently smoke tobacco? Yes ___ No ___ **If yes,** how often and how many per day? _____
Do you currently use marijuana? Yes ___ No ___ **If yes,** how much do you use per week? _____
Are you taking any medications? Yes ___ No ___ **If yes,** name the medication(s) and dosages below
_____

Do you have any allergies to medicine? Yes ___ No ____ **If yes,** please list medicine _____
Have you ever been hospitalized? Yes ___ No ___ **If yes,** give dates and details _____
_____
Have you ever had surgery? Yes ___ No ___ **If yes,** give dates and details _____
_____

Please indicate if you or your immediate family members have had any following problems: **Check here if none** [ ]

[ ] Asthma [ ] High Blood Pressure [ ] Diabetes [ ] Hepatitis Substance Abuse [ ] Heart Disease
[ ] Stroke [ ] Tuberculosis [ ] Alcoholism [ ] Cancer Kidney Disease [ ] Sinusitis

Please indicate if you have had any of the following symptoms consistently: **Check here if none** [ ]

[ ] Sleeplessness	[ ] Chest Pain	[ ] Constipation	[ ] Nausea	[ ] Diarrhea	[ ] Loss of Appetite
[ ] Stomach Pain	[ ] Depression	[ ] Vomiting	[ ] Anxiety	[ ] Rectal Pain	[ ] Swollen Ankles
[ ] Skin Rashes	[ ] Palpitations	[ ] Headaches	[ ] Chronic Pain	[ ] Fever	[ ] Muscle Spasms
[ ] Coughing	[ ] Heart Burn	[ ] Seizures	[ ] Eye Problems	[ ] Blood in Bowels	[ ] Difficulty Swallowing

Describe any other health problems that occur frequently with you or in your family _____

_____

_____

I hereby declare that I have completely and truthfully disclosed all information regarding my medical condition and attest that I am not a member, employee or agent of any media or law enforcement agency. It is illegal for a patient to film or record in this office with video camera, cell phone or any other recording device whether still image, video or audio. This is a direct violation of HIPAA regulations and patient/doctor confidentiality.

I am aware that my approval or recommendation may be revoked at any time if I have perjured or misrepresented myself or my condition.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT

Patient Signature _____ Physicians Initials _____

Informed Consent: Risks and Side Effects, Release of Liability

Patient's Name _____DOB____/___/____

Address _____

_____CA_____
city zip

Please read each item below and initial in the space provided to indicate that you understand the information regarding the risks and side effects of using cannabis. I agree to tell the attending physician if I do not understand any of the information provided.

I understand that the cultivation, possession and use of cannabis, even for medical purposes, are currently illegal under federal law. _____

I understand that cannabis is not regulated by the USFDA and therefore may contain unknown quantities of active ingredients, impurities and or contaminants. _____

I understand that the attending physician, including the physician's employees, may not provide information regarding where medicinal cannabis might be obtained. Doing so would be a violation of federal law. _____

The efficacy and potency of cannabis varies widely depending on the cannabis strain and ingestion method. Under federal law, the attending physician is unable to discuss dosage. _____

Symptoms of a cannabis overdose include, but are not limited to, nausea, vomiting, numbness, irregular heartbeat, drowsiness, and anxiety. _____

In the event of an overdose, I am advised to lie down, relax, and rest. If the symptoms persist, I agree to contact the attending physician. _____

Cannabis smoke contains tars and may include carcinogens (chemicals that can cause cancer) that have potentially harmful effects including increasing the risk of respiratory diseases and cancer of the lungs, mouth and tongue. _____

There is little known regarding how cannabis may, or may not, react with other pharmaceutical or herbal medications. _____

Use of cannabis may result in higher and higher dosages due to user's development of a tolerance to cannabis. _____

I understand that the use of cannabis may affect my coordination and cognition. I agree not to operate heavy machinery, drive or engage in potentially hazardous activities while using cannabis. _____

I understand that it is against the law to drive a vehicle while using marijuana and that I can get a DUI for driving under the influence. _____

The use of a vaporizer, as an ingestion method, can substantially reduces the potentially harmful effects of smoking cannabis. _____

Informed Consent: Risks and Side Effects, Release of Liability

Cannabis may be ingested in a tincture or edible form that eliminates some of the potentially harmful effects of smoking. _____ (init)

I understand that any of the following side effects can result from the use of cannabis: _____(init)

(a) Short term memory loss
(b) Anxiety/Nervousness
(c) Irregular heart beat
(d) Dry mouth
(e) Slower reaction time
(f) Poor physical coordination
(g) Hunger
(h) Loss of appetite
(i) Dizziness
(j) Cough
(k) Dependency
(l) Confusion
(m) Impaired vision
(n) Feeling of euphoria
(o) Drowsiness
(p) Headache
(q) Nausea/Vomiting
(r) Tiredness
(s) Apathy
(t) Depression
(u) Changes in sleep patterns
(v) Numbness
(w) Laryngitis
(x) Bronchitis
(y) Shortness of breath
(z) Agitation/irritability
(aa) Trouble concentrating
(bb) Low blood pressure
(cc) Sedation
(dd) Difficulty completing complex tasks
(ee) Inability to concentrate
(ff) Paranoia, psychotic symptoms (delusions)
(gg) Suppression of immune system
(hh) Talkativeness
(ii) Impairment of motor skills, reaction time, coordination

I understand that there may be benefits and risks associated with the use that have not been identified. _____

I agree to stop using cannabis and inform the attending physician in the event that I experience depression, have thoughts of suicide, or any other mental problems. _____

I also agree to inform the attending physician of any anti psychotic medication that I may be taking currently or in the future. _____

Informed Consent: Risks and Side Effects, Release of Liability

There is a possibility that cannabis may worsen schizophrenia in persons predisposed to that disorder. _____

I agree to stop using cannabis and inform the attending physician if I am experiencing any negative side effects that may be caused from my therapeutic use of cannabis. _____

There is the possibility of experiencing withdrawal symptoms when I stop using cannabis. I understand that these withdrawal symptoms can include, but are not limited to, depression, irritability, insomnia, loss of appetite, and tiredness. _____

I understand that cannabis is not recommended while under the influence of alcohol. _____

Patient's Release of Liability

I hereby state that I fully understand the potential risks and side effects related to the use of cannabis as described above. _____
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Furthermore, in using cannabis therapeutically, I accept full responsibility in assuming the risks and side effects related to its use. _____

I agree that the attending physician and his/her principals, agents, and employees, shall not be held responsibility for any harm resulting to me and/or other individuals as a result of my medicinal use of cannabis. _____

Patient Signature_____ Physicians Initials_____

Date _____/_____/20_____

Patient's Authorization for Release of Medical Records

_____

Name

_____

Street City State Zip

hereby authorize Serenity Medical Evaluations located at 3845 La Sierra Avenue, Suite 200D, Riverside, CA 92505,and/or 3767 Riverside Drive F Chino, CA 91710 to disclose and verify me as a patient to any law enforcement agency, my physician(s), Child Protective Services, Department of Public Health Services, or any representative of a medical cannabis Collective or Cooperative.

I understand if the organization I have authorized to receive my health information, is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I authorize Serenity Medical Evaluations to validate my status as a patient, with an approval for the therapeutic use of cannabis, using a HIPAA compliant on-line verification system.

This authorization is valid during the period of time for which the physician's approval, for the use of cannabis, has been issued.

This consent is voluntary and subject to written revocation at any time except to the extent that action has already been taken on the basis of consent.

I give permission for my medical records and file to be reviewed by another physician working with Serenity Medical Evaluations. I understand that this might happen if the original physician that evaluated me needs a secondary opinion or is not available.

By signing this, I hereby acknowledge that I have read and understand the Health Insurance Portability and Accountability (HIPAA) Notice of Privacy Practices and hereby acknowledge receipt of a copy for my records.

Patient Signature _____

Date:_____/_____/_____