THE HOLISTIC CLINIC

IDENTIFYING DATA:

Last name: ______________________________ First name: ______________________________ MI: ______________
Birth date: ____________________________Age__________ Gender: ❑ Male ❑ Female
Driver's License #: ______________________________
Address: ____ City: ________________ State: ______ Zip: _________
Home phone: _____________________ Work phone: ____________________ Cell phone: ____________________
Email: ____
Best time to contact: ____________________________________ ❑anytime ❑morning ❑afternoon ❑evening
Race: ❑African ❑Asian ❑Hispanic ❑ Caucasian ❑ Native American ❑ Pacific Is. ❑Others_________
Occupation(s): ____
Current employment: ❑Full Time ❑Part Time ❑Unemployed ❑Retired ❑Disabled
Emergency contact: *(Name, Relationship, Phone)* ____

DEMOGRAPHIC INFORMATION:

Birthplace: ____

Years of education: ❑<10 ❑11 ❑12 ❑13 ❑14 ❑15❑16 ❑>16 Degree(s) obtained:
____

Major or Area of Specialty: ____

Occupation(s) / Other Training, Certifications: ____

Military: ❑Yes ❑No Branch of Service: ❑Army ❑Air Force ❑Marines ❑Navy ❑Coast Guard
Service in Viet Nam: ❑Yes ❑No Gulf War: ❑Yes ❑No Other: __________ Highest Rank: _____________

Length of Service: From ___ to _____ Discharge: ❑Honorable ❑Dishonorable ❑General ❑Medical ❑ others

Marital status: ❑Single ❑Married ❑Partner ❑Widowed ❑Divorced ❑Separated
Living Situation: ❑alone ❑with spouse ❑partner ❑with parent(s) ❑with children ❑with friend(s)
Domicile: ❑house ❑mobile home ❑apartment ❑institution ❑homeless ❑others ________
Household members: first name, age and relationship

____
____

GENERAL INFORMATION:

Do you have medical insurance? ❑Yes ❑No
If yes, Identify: ❑MediCal ❑Medicare ❑HMO ❑PPO ❑Kaiser ❑None ❑Others:___________

Primary care physician or clinic, Name: ________________________________Phone: ____________________
Address ____ City ___________________ Zip ____________
Specialist / Consultant, Name and Location: ____
Specialist / Consultant, Name and Location: ____

MEDICAL HISTORY

Chief Complaint(s):
What is the main problem for which you seek evaluation and treatment today (or the main reason you currently use cannabis) i.e. nausea, anorexia, spasms, pain, etc.? ____

____

____

When did this problem start?
❑< 1 month ❑< 1 year ❑1 – 3 years ❑3 – 5 years ❑5 – 10 years ❑> 10 years

When did you last see your doctor or a specialist about this complaint?
❑< 1 month ❑< 1 year ❑1 – 3 years ❑3 – 5 years ❑5 – 10 years ❑> 10 years

Check treatment modalities that you have tried in treating your problem:
❑ Medications ❑ Surgery ❑ Therapeutic injections ❑ Physical therapy ❑ Osteopathic Care
❑ Chiropractic Care ❑ Acupuncture ❑ Counseling ❑ Others: ____________________

Current Prescription Medications: *List names, dosage, frequency of use, and how long taken*
1. ____________________Dosage ________________ Frequency ___________ Duration ________________
2. ____________________Dosage ________________ Frequency ___________ Duration ________________
3. ____________________Dosage ________________ Frequency ___________ Duration ________________

Previous Prescription Medications: *(relevant) names, duration, and reasons of stopping.*
1. __________________ _______________________ ____
2. __________________ _______________________ ____
3. __________________ _______________________ ____

Over-the-Counter and Herbal Medications: *List products that you use or have used in the past for the condition for which cannabis is used (intended), i.e. ibuprofen, aspirin, glucosamine, milk thistle.*

____

____

ALLERGIES:

Medication Intolerance: ❑ Yes ❑ No Explain: ____________________________________
Food Allergies: ❑ Yes ❑ No Explain: ____________________________________

OTHER DRUG USE:

Tobacco: ❑Yes ❑No Cigarettes / day _____________ Years of smoking _______ Quit date ________
Alcohol: ❑Yes ❑No Drinks / day or week ___________ Years of drinking _______ Quit date ________
Caffeine: ❑Yes ❑No Cups / day [Coffee ___ Tea ___ Soda ___] Years of drinking _______ Quit date ________
Opiates / Heroin: __________ times per month Years of use ___________ Quit date ________
Cocaine: __________ times per month Years of use ___________ Quit date ________
Amphetamines / Ecstasy __________ times per month Years of use ___________ Quit date ________
LSD / Psilocybin / Peyote: __________ times per month Years of use ___________ Quit date ________

MEDICATION REVIEW

Please ✓ the medication(s) that you have tried in the past.

- ❑ Acetaminophen
- ❑ Ambien
- ❑ Amitriptyline
- ❑ Aspirin
- ❑ Atarax
- ❑ Baclofen
- ❑ Benadryl
- ❑ Bupropion
- ❑ BuSpar
- ❑ Cannabinoids
- ❑ Capsaicin
- ❑ Carbamazepine
- ❑ Celebrex
- ❑ Clonazepam
- ❑ Codeine
- ❑ Cymbalta
- ❑ Dalmane
- ❑ Darvocet
- ❑ Darvon
- ❑ Depakote
- ❑ Desipramine
- ❑ Dexamethasone
- ❑ Diazepam
- ❑ Diclofenac
- ❑ Diflunisal
- ❑ Dilantin
- ❑ Doxepin
- ❑ Duloxetine
- ❑ Effexor
- ❑ Elavil
- ❑ Etodolac
- ❑ Fenoprofen
- ❑ Fentanyl
- ❑ Flecainide
- ❑ Flexeril
- ❑ Fluoxetine
- ❑ Flurbiprofen
- ❑ Forte
- ❑ Gabapentin
- ❑ Halcion
- ❑ Hydrocodone
- ❑ Hydromorphone
- ❑ Hydroxyzine
- ❑ Ibuprofen
- ❑ Imipramine
- ❑ Indocin
- ❑ Indomethacin
- ❑ Ketoprofen
- ❑ Ketorolac
- ❑ Lamictal
- ❑ Lamotrigine
- ❑ Levorphanol
- ❑ Lidocaine
- ❑ Lyrica
- ❑ Meclofenamate
- ❑ Mefenamic acid
- ❑ Meperidine
- ❑ Methadone
- ❑ Mexiletine
- ❑ Morphine
- ❑ MS-Contin
- ❑ Nabumetone
- ❑ Naprosyn
- ❑ Naproxen
- ❑ Neurontin
- ❑ Norflex
- ❑ Norpramin
- ❑ Nortriptyline
- ❑ Oramorph SR
- ❑ Oxaprozin
- ❑ Oxycodone
- ❑ Oxycontin
- ❑ Oxymorphone
- ❑ Pamelor
- ❑ Parafon
- ❑ Paroxetine
- ❑ Paxil
- ❑ Percocet
- ❑ Phenytoin
- ❑ Piroxicam
- ❑ Prednisone
- ❑ Pregablin
- ❑ Propoxyphene
- ❑ Prozac
- ❑ Robaxin
- ❑ Roxicodone
- ❑ Salsalate
- ❑ Sinequan
- ❑ Soma
- ❑ Sulindac
- ❑ Tegretol
- ❑ Tofranil
- ❑ Tolmetin
- ❑ Topamax
- ❑ Topiramate
- ❑ Tramadol
- ❑ Trilisate
- ❑ Tylenol #3
- ❑ Tylenol #4
- ❑ Ultram
- ❑ Valium
- ❑ Valproic acid
- ❑ Venlafaxine
- ❑ Vicodin
- ❑ Vioxx
- ❑ Vistaril
- ❑ Wellbutrin
- ❑ Xanax
- ❑ Zoloft
- ❑ Others: ___________

PAST MEDICAL HISTORY

(✓ check the box most applicable to you)

- ❑ Arthritis
- ❑ Back and neck pain
- ❑ Blood Disorders (anemia, abnormal clotting)
- ❑ Brain disorders (epilepsy, trauma, etc)
- ❑ Breast lesions
- ❑ Cancer, specify:
- ❑ Chronic pain, specify:
- ❑ Circulation (stroke, phlebitis, etc)
- ❑ Diabetes
- ❑ Dystonia (spasms, tremors, Parkinson's)
- ❑ Ear problems (tinnitus, hearing loss)
- ❑ Eating disorder (anorexia, bulimia)
- ❑ Endocrine problems (thyroid, hormones)
- ❑ Eye problems (glaucoma, cataracts)
- ❑ Genital / GYN problems
- ❑ Heart disease
- ❑ Herpes zoster / shingles / other
- ❑ High blood pressure
- ❑ HIV/AIDS
- ❑ Intestinal disorders (ulcers, colitis, IBS)
- ❑ Kidney disease (cystitis, renal failure)
- ❑ Liver disease (cirrhosis, hepatitis B or C)
- ❑ Lungs disease (asthma, emphysema)
- ❑ Mental disorders (depression, anxiety, PTSD)
- ❑ Migraine headache
- ❑ Multiple sclerosis (neurodegenerative disease)
- ❑ Prostate disease
- ❑ Rheumatic disease (Lupus, Sjogrens, Reiters)
- ❑ Skin disorders (psoriasis, eczema)
- ❑ Sleep disorders (insomnia, sleep apnea)
- ❑ Substance abuse (tobacco, alcohol, other drugs)
- ❑ Weight loss / gain

FEMALES REPRODUCTIVE HISTORY *(female's only):*

Number of pregnancies _________ Number of children _________ Children's present ages _______________

Are you pregnant now? ❑Yes ❑No Are you planning a pregnancy? ❑Yes ❑No

Are you currently breastfeeding? ❑Yes ❑No

PAST SURGICAL HISTORY: *Please list in chronological order surgeries and approximate dates.*

1. ____ Date: ______________
2. ____ Date: ______________
3. ____ Date: ______________

REVIEW OF SYSTEMS

Symptoms: Check [X] symptoms you currently have or have had in the past year.

	GENERAL		GASTROINTESTINAL		EYE, EAR, NOSE, THROAT		MEN only
	Chills		Abdominal pain or cramps		Bleeding gums		Breast lump
	Depression		Appetite poor		Blurred vision		Erection difficulties
	Dizziness		Bloating		Crossed eyes		Lump in testicles
	Fainting		Bowel changes		Difficulty swallowing		Penis discharge
	Fever		Constipation		Double vision		Sore on penis
	Forgetfulness		Diarrhea		Ear discharge		
	Headache		Excessive hunger		Earache		**WOMEN only**
	Loss of sleep		Excessive thirst		Hay fever		Abnormal Pap Smear
	Loss of weight		Gas		Hoarseness		Bleeding between periods
	Nervousness		Hemorrhoids		Loss of hearing		Breast lump
	Numbness		Indigestion		Nosebleeds		Extreme menstrual pain
	Poor energy		Nausea		Persistent cough		Hot flashes
	Sweats		Rectal bleeding		Ringing in ears		Nipple discharge
			Stomach pain		Sinus problems		Painful intercourse
	MUSCLE/JOINT/BONE		Vomiting		Vision — Flashes		Vaginal discharge
	Pain, weakness, numbness in:		Vomiting blood		Vision — Halos		
	Arms / Hips						**ENDOCRINE**
	Back / Legs		**CARDIOVASCULAR**		**INTEGUMENTARY**		Goiter
	Feet / Neck		Cardiac palpitations		Bruise easily		Hot or cold intolerance
	Hands / Shoulders		Chest pain or angina		Change in moles		Sexual dysfunction
	Arthritis / Muscle Cramp		High blood pressure		Hives		
			Irregular heart beat		Itching		**HEMATOLOGIC/ LYMPHATIC**
	GENITO-URINARY		Low blood pressure		Rash		Anemia
	Blood in urine		Poor circulation		Scars		Bleeding tendency
	Frequent urination		Rapid heart beat		Sore that won't heal		Blood disorder
	Lack of bladder control		Swelling of ankles				Blood transfusion
	Painful urination		Varicose veins		**RESPIRATORY**		
	Stones or Gravel				Asthma		
	Urinary leakage		**NEUROLOGICAL**		Bronchitis		
			Disturbance of speech		Cough		
	PSYCHIATRIC		Dizziness, vertigo		Cyanosis		
	Anxiety		Fainting		Painful breathing		
	Depression		Headache		Pneumonia		
	Disturbing feelings		Numbness		Shortness of breath		
	Panic attack		Seizures		Sputum with blood		
	Restlessness		Tingling		Tuberculosis		
			Weakness		Wheezing		

Conditions: Check [X] conditions you currently have or have had in the past year.

	AIDS		Chemical Dependency		High Cholesterol		Prostate Problem
	Alcoholism		Chicken Pox		HIV Positive		Psychiatric Care
	Anemia		Diabetes		Kidney Disease		Rheumatic Fever
	Anorexia		Emphysema		Liver Disease		Scarlet Fever
	Appendicitis		Epilepsy		Measles		Stroke
	Arthritis		Glaucoma		Migraine Headaches		Suicide Attempt
	Asthma		Goiter		Miscarriage		Thyroid Problems
	Bleeding Disorders		Gonorrhea		Mononucleosis		Tonsillitis
	Breast Lump		Gout		Multiple Sclerosis		Tuberculosis
	Bronchitis		Heart Disease		Mumps		Typhoid Fever
	Bulimia		Hepatitis		Pacemaker		Ulcers
	Cancer		Hernia		Pneumonia		Vaginal Infections
	Cataracts		Herpes		Polio		Venereal Disease

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CANNABIS USE PATTERN

How often do you use cannabis?

❑1 times per month ❑2 – 3 x / week ❑1 x / day ❑2 x / day ❑3 x / day ❑4 x / day ❑> 4 x / day

Estimate the average amount of cannabis you use per day? *(large joint = 1 gram, 1/8 oz. = 3.5 gm)*

❑< 1 gram ❑1 gram ❑2 grams ❑3 grams ❑4 grams ❑5 grams ❑6 grams ❑others: ________

Has the amount of cannabis needed to control your symptoms changed over time?

❑much more ❑little more ❑about the same ❑little less ❑much less ❑variable

If changed, to what do you attribute the change: ____

____

How effective is cannabis in treating your condition?
❑Much better (very effective) ❑Better (effective) ❑Slightly better (somewhat effective)

How does cannabis compare with your usual prescribed medicines in relieving your symptoms?

❑Prescribed medicines work <u>much better</u> ❑Cannabis works a <u>little better</u> than prescribed medicines

❑Prescribed medicines work a <u>little better</u> ❑Cannabis works <u>much better</u> than prescribed medicines

❑Prescribed medicines work <u>no better</u> ❑Cannabis and prescribed medicines work <u>best together</u>

Explain: ____

Have you ever stopped using cannabis only to find that your symptoms return or worsen? ❑Yes ❑No

Explain: ____

If your symptoms disappear or are substantially reduced would you keep on using cannabis? ❑Yes ❑No

Describe bothersome adverse effects that you have to cannabis: _________________________________

Are there other reasons for which you use cannabis? _______________________________________

Has your cannabis use affected your relationship with your family?

❑no change ❑slightly ❑a lot ❑not applicable

Medical Marijuana Acknowledgement of Disclosure and informed consent

Read each item below and initial in the space provided to indicate that you understand and agree to each item. Do not sign this agreement and do not use medical marijuana if you have questions about or don't understand the information you have received.

I, ________________________________(patient's full name), Understand that medical marijuana is a medicine use=d treating the suffering caused by serious and debilitating medical conditions. Serious medical conditions include (but are not limited to):Anorexia, Arthritis, Cachexia, Cancer, Glaucoma, HIV, Migraines, Muscle Spasm, Seizures, Chronic Pain, and Severe Nausea. Additionally, medical marijuana is used in the treatment of other chronic or persistent medical symptoms that: Substantially limit the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336) If not alleviated may cause serious harm to the patient's health.

I have been advised and understand that the use of cannabis may affect my coordination and cognition in ways that could impair my ability to drive, operate heavy machinery, or engage in potentially hazardous activities. I assume full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis.
Initials______

Although smoking marijuana has not been linked to lung cancer, smoking can cause respiratory harm such as bronchitis. I am advised that the cannabis (medical marijuana) smoke contains chemicals known as tars that may be harmful to my health. Recent research indicates that vaporizing cannabis may eliminate exposure to tar. Should respiratory problems or other ill effects be experienced in association with its use, it should be discontinued and reported to the physician.
Initials______

I understand the side effects may occur while I am consuming medical marijuana. These side effects have been explained to me. Side effects of marijuana can include, but are not limit to euphoria; sedation; dizziness; anxiety; confusion; fatigue; inability to concentrate; difficulty in completing complex tasks; impairment of motor skills; impaired perception; diminished short-term memory; Dry mouth; slowness;, loss of concentration and coordination; impaired judgment; increase risk of accidents; loss of motivation; diminished inhibitions; increased heart rate, anxiety, panic attacks, and paranoia; hallucinations; damage to the respiratory, reproductive, and immune systems; increase risk of cancer; and psychological dependency; psychotic symptoms.
Initials______

Marijuana varies in potency. The effects of marijuana can also vary with the delivery method. Estimating the proper marijuana dosage is very important. Systems of a marijuana overdose include nausea, numbness of the limbs, hackling cough and vomiting.
Initials______

For some patients, chronic marijuana overdose can lead to laryngitis, bronchitis, or general apathy.
Initials______

Using marijuana may decrease reproductive functions in men as well as woman. Woman, who are trying to conceive, or are pregnant or breast feeding should not use marijuana. This means they experience withdrawal symptoms when they stop using marijuana. Sighs of withdraw, while generally mild can include feeling depressed, sadness, irritability, restlessness, or mild agitation, insomnia, sleep disturbances, unusual tiredness, trouble concentrating, loss of appetite.
Initials______

Although marijuana does not produce a specific psychosis, the possibility exist that it may exacerbate schizophrenia in persons predisposed to that disorder
Initials______

I understand that using marijuana while under the influence of alcohol is not recommended.
Initials______

I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities and/or contaminants. I understand the potential risks associated with an elevated daily consumption of marijuana including risks with respect to the effect on my cardiovascular and pulmonary systems and psychomotor performance, risks associated with the long-term use of marijuana, as well as potential drug dependency. I am aware that the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. In requesting an approval or recommendation for the use of this plant as medication, I assume full responsibility for any and all risks of this action.
Initials______

I have been assured that records relating to my care will be kept confidential and that no information will be released or printed that would disclose personal identity, unless required by law, or for verifications on your behalf.
Initials______

I certify and declare under penalty of perjury that I have read and understood the information contained herein, and the information I have given is true and complete. I promise to make the physician aware if I am on probation, or have had a possession charge in the past
Initials______

I take full responsibility for my actions and agree not to hold The Holistic Clinic nor any physician or staff at The Holistic Clinic responsible for my actions.
Initials______

PATIENTS FULL NAME (print) ____________________________________ PATIENT SIGNATURE________________________________

DATE_____________________________

Medical Marijuana Patient Agreement

I agree to tell the attending physician if I have ever had symptoms of depression, been psychotic, attempted suicide, or had any mental problems. I also agree to tell the attending physician in I have ever been prescribed or taken medicine for any of these problems.
Initials______

I understand that the attending physician does not suggest nor condone that I cease treatment of medications that stabilize my mental or physical condition. I affirm that I have a serious medical condition that adversely affects my quality of life. I have found or an interested in finding weather cannabis provides relief and improvement for my condition. If I start taking medical marijuana, I agree to inform my physician if I start to feel sad, lose my appetite, become unusually tired, lose interest in activities, have change in my sleeping patterns, become more irritable than usual, or have withdraw from family and friends.
Initials______

I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities and/or contaminants. I understand the potential risks associated with an elevated daily consumption of marijuana including risks with respect to the effect on my cardiovascular and pulmonary systems and psychomotor performance, risks associated with the long-term use of marijuana, as well as potential drug dependency. I am aware that the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. In requesting an approval or recommendation for the use of this plant as medication, I assume full responsibility for any and all risks of this action.
Initials______

I understand California's Compassionate Use Act of 1996, (Health & Safety Code #11362.5), provides for the possession and cultivation of cannabis (medical marijuana) for the personal medical purposes of the patient with a physician approval or recommendation. It should be made absolutely clear that the physician, staff and representatives of this practice are neither providing cannabis, nor are they encouraging any illegal activity in my obtaining cannabis (medical marijuana).
Initials______

I understand that the use of cannabis may affect my coordination and cognition in ways that could impair my ability to drive, operate heavy machinery, or engage in potentially hazardous activities. I assume full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis.
I understand some users develop a tolerance to marijuana, this means higher doses are required to achieve the same pain relief. If I think I may be developing a tolerance to marijuana, I will notify my attending physician. I will notify my attending physician
Initials______

I will notify my attending physician should repertory problems or other ill effects be experienced in association with the use of medical marijuana, I agree to discontinue its use and report such problems to the attending physician.
I understand that the attending physician, staff, management, and representatives who associate with the physicians practice, are neither providing nor dispensing cannabis, nor are they encouraging any illegal activity in obtaining medical marijuana.
At this time, Cannabis is an alternative or complementary treatment. I understand to receive a recommendation to use cannabis legally in California I should have tried, or be willing to consider trying, at least one other recommendation treatment from a medical provider. I have obtained or attempted to obtain medical records pertaining to my condition or currently have no medical records pertaining to my condition and agree to be referred for further evaluation as the physician deems necessary.
Initials______

Release of Liability

I, THE UNDERSSIGNED, HERBY REQUEST A CONSULTATION BY A PHYSICIAN FOR THE PURPOSES OF DETERMINING THE APPRORIATENESS OF MEDICAL CANNABIS TREATMENT. THERE ARE NO CLAIMS ABOUT THE MEDICAL EFFICACYS OF CANNABIS. The physician, staff, representatives, and the attending physician of the holistic clinic are addressing specific aspects of my medical care, and unless otherwise started are in no way establishing themselves as my primary care provider. The physician is only rendering an opinion regarding the therapeutic value of the use of medical marijuana. Should an approval be made for my medical use of cannabis, I understand that there is a renewal date specified by the physician. Furthermore, the undersigned my heirs, assigns, or anyone acting on my behalf, hold the physician, staff, and representatives, free of and harmless from any responsibility and liability resulting from the use of cannabis.

PATIENTS FULL NAME (print) ___________________________________ PATIENT SIGNATURE__________________________________

DATE____________________________

You are now finished. Please turn this packet into the clinic manager. Thank you for choosing The Holistic Clinic.

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To be completed by the attending Physician

Name______________________________ Date_____________________
DOB_______________________________ Age_____________________

Chief Complaint:

____
____

PCP: Y/N
Does the PCP aware of patient's use of medical cannabis? Y/N
Last visit to the PCP: _________________
History of present illness

____
____
____
____
____
____
____

Past relevant medical and surgical history

____
____
____
____
____
____

Allergies: _________________
Smoking: _________________
Alcohol: ___________________

Physical Exam:

BP: ______ Pulse: ______ Resp: _______ WT: _____ HT: _____ Temp: _____

General appearance:____
Skin:____
Heent: ____
Heart/Lungs:____
Abdomen: ____
Neurologic Exam: ____
Mental Exam:____

Assessment:____
____
____
____

Recomendation____

____

____

____

Patient is informed, and accepts the risks and effects of marijuana. Yes ☐ **No** ☐

Follow Up

Duration ☐1mo ☐2 mo ☐3 mo ☐ 6 mo ☐9 mo ☐12mo ☐Other_______

Follow up ☐1mo ☐2 mo ☐3 mo ☐ 6 mo ☐9 mo ☐ 12mo ☐ By Phone ☐ In Person

Patient to bring medical records

____

____

Physicians' Signature ________________________________ Date ____________________