Holos Health Medical Cannabis Evaluation

Date: _____
Name: First_____ MI_____ Last_____
Social Security #:_____ *Please provide for state application
Date of Birth:_____ Phone #: _____ Email: _____
Mailing Address:_____

Have you ever had a Colorado MMJ License? YES NO Is your license current? YES NO
Have you been seen at Holos Health in the past? YES NO
If this is a renewal and you have not seen us in the past, can you recall where you went for your previous MMJ recommendation?_____
How did you hear about us?_____

Do you have medical insurance? YES NO If so, what company? _____
Do you have a primary care provider? YES NO If so, who? _____

Medical indication(s) for the use of medical cannabis (state qualifying condition):
_____
_____
_____
_____

Do you have access to medical records pertaining to the above condition(s)? YES NO
Did you bring medical records to your visit today? YES NO

Please list all other medical conditions: _____
_____

Hospital admissions or surgeries: _____
_____

Current Medications: _____
_____
_____

Medication/Other Allergies: _____
_____

Are you currently using cannabis? YES NO If so, what methods and frequency?
Smoke: bud _____ concentrates _____
Vaporize: bud_____ concentrates _____ dabs _____
Edibles: _____Tinctures: _____Patch or Cream:_____
Topicals:_____ Juicing: _____ Other:_____

Do you grow any of your own plants? YES NO Do you have a private caregiver? YES NO

Do you have a preferred dispensary? YES NO If so, which one? _____

Do you use tobacco? YES NO

Do you have a safe place to keep MMJ away from minors? YES NO

FLIP OVER →

Do you use, or have a history of abuse of alcohol or any other drugs (prescription or other)? If so, please explain: _____
_____
_____

Do you have a family history of any of the following; Cancer, cardiovascular disease, autoimmune disease, diabetes, genetic disorder, gluten sensitivity or Celiac disease, Senile dementia or Alzheimer's? If so, please explain: _____
_____
_____

Please write a brief description of your eating habits including any food limitations or special diet: _____
_____

Do you exercise? YES NO If so, what type and how often? _____
_____

FOR THOSE WITH SEVERE PAIN AS THEIR INDICATION:
Specify the areas of your pain: _____
Rate the intensity of your pain from 1-10 _____ (10 being most severe)
What other treatments have you tried for your pain? _____
_____
_____

FOR THOSE WITH A CANCER DIAGNOSIS:
Type and stage of cancer: _____
Forms of treatment (i.e. chemo, radiation surgery, etc.) _____
_____
_____
_____
Do you want to use cannabis for treating symptoms, as a potential chemotherapy agent or both? _____
_____

OTHER CONDITIONS FOR WHICH YOU WOULD LIKE TO ELABORATE:
Please state medical condition and give details: _____
_____
_____
Any other specific issues you would like to address today? _____
_____
_____

FOR OUR LADIES:
Are you currently breast-feeding, pregnant, or planning a pregnancy soon? _____
_____
Are you menopausal? YES NO If so, do you want to discuss bioidentical hormone replacement therapy with one of our doctors or our nurse practitioner? YES NO
Date of last menstrual period: _____
If using contraception, what method? _____

HIPAA PATIENT ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR HOLOS HEALTH

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Holos Health. A copy of the signed, dated Acknowledgement shall be as effective as the original. If you would like a copy of the Privacy Practices please ask the receptionist.

By providing your email address to Holos Health you are consenting to receive email reminders of appointments and weekly newsletters or updates. You may receive a reminder phone call from our office the day before a scheduled appointment.

Holos Health does not provide acute care. Phone calls will be accepted only during office hours Monday through Friday 9 AM to 5 PM (no weekends or after hour calls accepted). If you have an emergency please contact your closest urgent care center or emergency department.

We do not provide prescriptions for narcotics nor do we provide recommendations for disability.

Extended plant counts (over 6) can only be recommended for patients over the age of 30 with a debilitating, chronic medical condition.

Rare exceptions are made for patients under 30. Patients under 30 who are requesting an increased plant count are required to bring medical records of prior treatment of the chronic medical condition.

There is an additional fee for extended plant counts – no exceptions. Up to 12 plants is an additional $50. Anything above 12 plants is an additional $100.

All service sales are final and refunds are not permitted. Our staff is here to assist you with the state registration process within our means. The online registration process is in the responsibility of the patient. Our office does not have the ability to change the information input into a patient account once it has been submitted. You must contact the state directly regarding an issue with the online registration.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTHCARE INFORMATION: (This is optional)

Name: _____Relationship: _____

Name: _____Relationship: _____

CONTINUED CARE OFFICE POLICIES

ACKNOWLEDGEMENT OF RECEIPT OF CONTINUED CARE OFFICE POLICIES FOR HOLOS HEALTH

If you have any questions after your appointment please feel free to contact our office at 720-273-3568 and our cannabis nurse will return your call. Our nurse will triage all patient inquiries and review the chart with the providing practitioner to answer your questions appropriately. Our office policy allows each patient three brief correspondences whether it be by phone or email in between appointments. Beyond the three correspondences we will require a scheduled appointment to review concerns directly with your provider. The scheduled follow-up appointment may be in person or by phone.

If your case is more challenging, we'd like to encourage to book a second or third consultation with us; we would be happy to see you for continued care as many times as you need. We are here for you and would love to hear any updates with your care and testimonials as you continue using your cannabis as medicine.

The undersigned acknowledges receipt of the current Continued Care office policies for Holos Health. A copy of the signed, dated Acknowledgement shall be as effective as the original. If you would like a copy of these Policies please ask the receptionist.

Please print and sign your name below to acknowledge that you have read the above statements.

_____

Date

_____ _____

Please ***print*** your name here Please ***sign*** your name here