Welcome to Dr. Walker Wellness

Patient Information **Date: _____**

Name:

_____

Date of Birth: _____/_____/_____

Address:

_____

_____

City: _____ **State: _____** **Zip Code: _____**

Home Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____

Email:

_____

Gender: ☐ Male ☐ Female

Last 4 Numbers of Social Security Number: _____

How did you hear about Dr. Walker Wellness: ☐ Instagram ☐ Facebook ☐ Internet ☐ Friend

☐ Newspaper _____

☐ Referred by _____ ☐
Other_____

Your Primary care physician information

Name: _____

Address: _____

City: _____ State: _____

Have you had a medical marijuana recommendation from a doctor before? ☐ Yes ☐ No

If yes, please provide name of physician and/or practice

_____

_____

Past Medical History

Please list any medical conditions that you have ever been evaluated for by a physician, admitted to a hospital or are currently being treated for: (For example: HIV/Aids, Hepatitis C, Arthritis, Cancer, Glaucoma, Migraine Headaches, Weight Loss/Anorexia, Severe debilitating chronic pain, Neuropathy, Severe and persistent muscle spasms including but not limited to those characteristic of Multiple sclerosis or Crohn's disease, Seizures, Severe Nausea, High Blood Pressure, Depression, Anxiety, insomnia, Heartburn, Irritable Bowel, Chronic Bronchitis, Asthma, Chronic Allergies, or any other diseases affecting the kidneys, liver, nervous system, or bladder, Cachexia or wasting syndrome, agitation related to Alzheimer's disease.

_____

_____

Past Surgical History

Please list any surgeries that you have had in the past. Include the reason, date, hospital and doctor who performed the surgery.

_____

_____

Review of Symptoms:

General

- ☐ Anxiety
- ☐ Chronic Pain
- ☐ Insomnia/loss of sleep
- ☐ Headache
- ☐ Loss of weight

Gastrointestinal

- ☐ Abdominal pain or cramps
- ☐ Bowel changes
- ☐ Nausea
- ☐ Poor Appetite
- ☐ Vomiting

Muscle/Joint/Bone/Pain

- ☐ Neck
- ☐ Shoulder
- ☐ Back
- ☐ Arms
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Ankles
- ☐ Feet
- ☐ Arthritis
- ☐ Muscle Cramps

Psychiatric

- ☐ Anxiety

Cardiovascular

- ☐ Cardiac Palpitations

Neurological

- ☐ Fainting

☐ Depression ☐ High Blood Pressure ☐ Headache

☐ Disturbing feelings ☐ Irregular heartbeat ☐ Numbness

☐ Panic Attack ☐ Neuropathy

Current Conditions

☐ Aids ☐ Alcoholism Chemical Dependency ☐ Anorexia ☐ Anxiety ☐ Arthritis

☐ Cancer ☐ Chemical Dependency ☐ Chronic Pain ☐ HIV Positive

☐ Depression ☐ Epilepsy ☐ Fibromyalgia ☐ Glaucoma

☐ Insomnia ☐ Migraine Headaches

Others: _____

Medications

Over the counter_____

Prescribed _____

Chief Complaint

Please describe the medical condition(s) or complaints that you are seeking a recommendation for medical marijuana. (How long have you had symptoms/diagnosis?)

_____

_____

_____

Does this medical condition limit your ability to conduct major life activities? (Work, Eat, Sleep, Interact with others) ☐ Yes ☐ No

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Do you feel that if this medical condition is not alleviated, it could and will continue to cause significant harm to your physical health and or mental health and wellness? ☐ Yes ☐ No

Have you received medical care or evaluation by a physician/specialist for this medical condition? ☐ Yes ☐ No

If yes, please provide the **name**, **address** and **date last seen by the physician** (including chiropractor/acupuncture) that diagnosed and/or treated you for this medical condition/s:

_____

_____

If not listed, please describe all treatments that you have received to date for your current medical problems such as the medications prescribed, surgeries, physical therapy, acupuncture, homeopathy, or chiropractic care:

_____

_____

Do you currently smoke **cigarettes**? ☐ Yes ☐ No

If Yes, how much do you smoke? _____- a day.

<u>Cannabis (Marijuana) History</u>

Do you currently use cannabis to treat your current medical condition? ☐ Yes ☐ No

At what age did you discover that cannabis eased your symptoms? _____

Does cannabis provide relief for your symptoms? ☐ Yes ☐ No
If yes, please describe. (Example; less pain or nausea)

_____

_____

How often do you use marijuana: ☐ Daily ☐ Weekly ☐ Monthly

How much cannabis do you consume per treatment? _____

What method do you currently use to consume the cannabis? (Please check all that apply)

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☐ Vaporize ☐ Ingest/edible ☐ Smoke ☐ Anointing oil

Additional Information

Please provide any other information you believe is relevant to the doctor's evaluation:

_____

_____

_____

_____

I understand that the physician may be contacted to verify and/or authorize my status as their patient as well as any prescription and/or recommendation that may or may not be issued by them. By signing below I hereby authorize the physician and/or Dr. C Walker Wellness to make such verifications or authorization. My signature below shall serve as a release for this purpose only and shall not serve as a waiver of my other patient and physician privacy rights as detailed under Massachusetts State Laws and Federal HIPAA regulations.

Patient Signature_____ Date___/___/_____