Answer to the best of your knowledge and leave blank any sections that you cannot answer, or do not apply

# *Patient Intake*

Date:_____

Patient Name: _____ DOB: _____
Address:_____
Email Address: _____ Referred By:_____
Cell #:_____ Home phone #: _____
Name/phone of Primary Care Physician:_____ #_____
Emergency Contact:_____ #_____
What is your qualifying Medical Condition?_____
When did your Condition start?_____
Do you have medical records for your condition?_____

What treatment have you received for this condition?

_____
_____

Are you currently a cardholder with the state of Arizona or elsewhere (Please specify the state)?_____

If yes, does Cannabis help your condition? _____

**Medical Information**:

Please list any surgeries or hospitalizations along with date of occurrence.

_____
_____

Please list all medications and supplements you are taking or have recently taken.

_____
_____
_____

Please read through the following chart of symptoms and "check" any that you currently experience or have in the past:

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|---|
| **General**: ❑hot ❑cold ❑chills ❑fever ❑sweats ❑ night sweats ❑weight loss ❑ weight gain ❑ fatigue ❑restless legs ❑snoring ❑excessive sleepiness ❑difficulty initiating sleep ❑difficulty maintaining sleep ❑anemia ❑excessive bruising or ❑ bleeding |
| **Skin:** ❑rashes ❑itching ❑excessive sweating ❑nail/hair abnormalities or changes ❑ discoloration |
| **Head**: ❑headaches/pain ❑head injury ❑migraines<br>**Eyes**: ❑double vision ❑blurred vision ❑cataracts ❑vision changes ❑ eyestrain ❑ itchiness<br>**Ears**: ❑discharge ❑hearing changes ❑tinnitus (ringing) |

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| |
|---|
| **Nose**: ❑sinusitis ❑decreased smell ❑congestion ❑bloody nose ❑runny nose ❑allergies<br>**Mouth/Throat**: ❑tenderness or lesions ❑sore throats ❑persistent hoarseness ❑difficulty swallowing<br>**Neck**: ❑ pain or tenderness |
| **CHEST**: ❑ asthma ❑bronchitis ❑COPD ❑chronic cough ❑ productive cough: blood/mucus ❑ hyperventilation ❑ shortness of breath ❑ pain |
| **CARDIOVASCULAR**: ❑angina ❑Congestive Heart Failure ❑Coronary Artery Disease ❑dizziness ❑ Hypertension ❑ fainting ❑stroke ❑ atherosclerosis ❑ poor circulation |
| **GASTROINTESTINAL**: ❑constipation ❑diarrhea ❑black stools ❑gallbladder problems ❑nausea ❑vomiting ❑hemorrhoids ❑gas/bloating ❑jaundice ❑rectal bleeding ❑heartburn |
| **GENITOURINARY**: ❑rectal pain ❑pain with urination ❑blood in the urine ❑ frequent urination ❑discharge ❑change in frequency of urination ❑hesitancy ❑incontinence ❑chronic Urinary Tract Infections ❑Sexually Transmitted Infection ❑ kidney stones |
| **Females OB/GYN**: **# of pregnancies___ # of children ___**<br>**Last Menstrual Period**:<br>Last Pap: (date) _____<br>Last Mammogram: (date) _____ |
| **BREASTS**: ❑discharge ❑enlargement ❑pain ❑tenderness ❑prior surgery or biopsy |
| **NEUROMUSCULAR**: ❑ muscle/nerve pain ❑tingling/numbness ❑arthritis ❑nervousness ❑vertigo ❑weakness |
| **MENTAL/EMOTION:** ❑depression ❑anxiety ❑panic attacks ❑rage ❑ memory loss |

If you experience pain, please mark the location(s) of your pain/tenderness/discomfort on the following diagram: