Releaf Cannabis Clinic, LLC
Flavia L. Thomas, DO
P (346) 433-1579 F (833) 579-2806
Email address ReleafcannabisRX@gmail.com

# *COMPASSIONATE USE PROGRAM INTAKE FORM*

**Releaf Cannabis Clinic, LLC**

***PERSONAL INFO:*** ***Please enter your information (EXACTLY AS IT APPEARS ON YOUR CURRENT DRIVER'S LICENSE). This helps avoid application denial by the State.***

**First Name** on Driver's License:* _____

**Middle Name** on Driver's License:*_____

**Last Name** on Driver's License:* _____

**Gende**r: * **Female ( ) Male ( )**

**Date of Birth**:* **Month**_____ **Day**_____ **Year**_____

**Weight** (guesstimate):*_____ **Height** (ft and in):* _____

***Address*** **(**as it is on current Driver's License or ID**):***

_____

**Apt./Unit #:**_____

**City:*** _____

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

**County (Texas): *** _____

**Mobile Phone: *** _____

**Email (Required):*** _____

**Last 5 SSN (State Required): *** _____

(*) Required information

Please initial here:_____

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***CHIEF COMPLAINT:*** **(**Please describe the main issue you're experiencing)**: ***

**How long have you had this problem? (** Be as specific as possible):*

**How severe is this problem? Mild ( ) Moderate ( ) Severe ( )**

**Have you tried anything to address this problem? Did it help? ( ) Yes ( ) No**

## ***MEDICAL HISTORY*: (**Please circle all conditions that applies to you**): ***

Abdominal pain / Cramps Acid Reflux / GERD / Barrett's Esophagus ALS (Lou Gehrig's Disease) Anxiety / Panic attacks Anorexia (Poor Appetite) Asthma /Autistic Spectrum Disorders /Autoimmune Disorder (specify type below)/ Attention Deficit Disorder/ Back Pain (Bulging, Herniated, Slipped)/ Bipolar Disorder / Blood Disorder / Cancer (specify type below)/ Cerebral Palsy / Chronic Fatigue Syndrome / Chronic Pancreatitis / COPD / Emphysema / Crohn's Disease/ Depression / Diabetes (type I or II)/ Degenerative Disc Disease (specify spine level)/ Eczema / Dermatitis / Endocrine Disorder/ Endometriosis / Epilepsy / Seizures / Eye Disease / Fibromyalgia/ Gastrointestinal Disease / Genetic Mutation (specify type below)/ Gouty Arthritis/ Glaucoma / Headaches (Migraine, Cluster or Tension) / Heart Disease (specify type below)/ Hepatitis / HIV/AIDS / Hypertension / High Blood Pressure/ Insomnia/ Irritable Bowel Syndrome/ Joint Pain (specify joint below/ ) Knee Pain / Kidney Disease / Liver Disease/ Lung Disease / Lupus (SLE) / Lyme disease / Menopause / Multiple Sclerosis / Muscle spasms/Spasticity / Muscular Dystrophy / Nausea / Vomiting / Neck Pain / Neurologic Disorder/ OCD / Osteoarthritis/ Osteoporosis / Parkinson's disease / Peripheral Neuropathy (numbness & tingling) / Psoriasis/ PMDD (painful menstrual periods) / PTSD (Post Traumatic Stress Disorder)

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Liver Disease/ Restless Leg Syndrome (RLS) / Rheumatoid Arthritis / Schizophrenia / Sleep Apnea / Spinal cord injury/ Stroke / TIA / TBI (Traumatic Brain Injury) Terminal condition/ Thyroid Problems / Tourette's / Traumatic Fracture / Traumatic Bone Fracture / Tremors/ Trigeminal neuralgia/ Ulcerative colitis / Vascular Disease/ Weight (Loss / Gain).

**Other:**_____

Please circle any ***TESTS/STUDIES*** done to evaluate your condition(s)**: ***

Allergy Testing/ Bone Scan (DEXA)/ Colonoscopy / CT Scan / EEG / EKG / EMG / Nerve Conduction Studies/ Endoscopy/ Genetic Tests / Hearing / Vision Test / Mammogram / Thermogram / MRI / PAP Smear / PET Scan / Sleep Study/ Ultrasound/ X-ray/ **NONE.**

**Others:**_____

***SURGICAL HISTORY* ( ***Circle any procedure that you may have had**):*

Adenoidectomy/ Appendectomy / Amputation/ Back Surgery / Biopsy / Bone Fracture / Repair Bowel Resection/ Brain Surgery / Breast Implant / C-Section/ Cardiac Defib / Pacemaker / Cardiac Stents / Carpal Tunnel / Cataracts / Chemotherapy port / Colon surgery / Coronary artery bypass (CABG) / Cosmetic Surgery / D&C / Dental / Oral Surgery/ Endometrial Ablation/ Eye Surgery/ Gallbladder / Hemorrhoidectomy/ Hernia Repair/ Hip Replacement / Hysterectomy / knee Arthroscopy / Knee Replacement / Laminectomy/ Laparoscopy/ Lumpectomy / Mastectomy/ Neck Surgery/ Nephrectomy/ Prostatectomy/ Sinus Surgery/ Skin Graft/ Spinal Fusion / Thyroidectomy / Tonsillectomy/ **NONE.**

**Others:** _____

***MEDICATIONS:* (**Prescription Medications, Over-The-Counter, Supplements /Vitamins)

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**Name** _____ **Dosage**_____

**Name** _____ **Dosage**_____

**Name** _____ **Dosage**_____

**Name** _____ **Dosage**_____

**Allergies?** ( ) **Yes** _____ ( ) **No Known Drug Allergy**

## *SOCIAL HISTORY:*

* Use **Tobacco**: ( ) **Yes**. Packs/Day:_____ . ( ) **Never**. ( ) In the **Past**, but I've quit.

*Drink **Alcohol**: ( ) **Yes** . Drinks/Day: _____. ( ) **Never**. ( ) In the **Past,** but I've quit.

*Use Illicit / Recreational **Drugs**: ( ) **Yes**. What kind:_____ ( ) **Never.**
( ( ) In the **Past**, but I've quit.

## *FAMILY HISTORY:* **(** Circle any condition that applies**):**

**Does anyone in your family (grandparents, parents, sibling or child) have a history of:**

Autoimmune Disease (specify below) / Blood Disorder (specify below) /Cancer (specify below)/ Dementia / Alzheimer's / Diabetes I or II / Glaucoma / Blindness / Heart Disease (specify below)/ High Blood Pressure / Stroke /Mental Health (specify below) / **None that I'm aware of** / **Other** (specify below) /**Please specify type of family Cancer or Mental Health here also:**
_____.

**Others:** _____

## *EMERGENCY CONTACT:*

**Emergency & Important Contact (...person that we may share your health info with)**

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**Emergency Contact:**

**Name**: _____**Relationship**: _____

**Phone**:_____

## *PLEASE NOTE:*

**If you do **NOT** have your medical records or any of above items **IN YOUR POSSESSION**, please fill out our **Medical Records Release Form** so we may obtain it from your healthcare provider directly.

**If you do **NOT** have **ANY** medical records because you have not seen a healthcare provider in **over 5** years, This will require an **additional evaluation** (additional **$150 fee**) to first help establish the **diagnosis** of your chronic medical condition **prior** to your Medical Marijuana Certification visit. You may also choose to reschedule and seek care outside of our office for the evaluation and diagnosis.

**** One Proof of TEXAS Residency is REQUIRED. (**WE NEED THIS TO BEGIN WORKING ON YOUR STATE APPLICATION ASAP**).**

**Examples Are:**

*Driver's License- current, not expired, paper renewals must have a photo
*ID Card with photo
*Passport- current, not expired
*Birth Certificate
*School ID- with photo

## *MARIJUANA USAGE:*

- These questions help to better understand you and your answers do NOT disqualify you from becoming a medical marijuana patient.
-

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- **Have you ever used marijuana ? ***
- **Yes** ( ) **No** ( )
- **Do you currently use marijuana ? (THERE IS NO PENALTY FOR ANSWERING "YES") ***
- **Yes** ( ) **No** ( )
- **If currently using marijuana, how often do you use/medicate?** Circle the frequency.
- Once a day Two times a day Several times a day 3-4 times a week
- 5-7 times a week Several times a month Several times a year
- **Has marijuana ever caused a bad reaction ? (For example:** racing heart, anxiety, dizziness, paranoia**)**
- ( ) YES, had a bad reaction. ( ) NO, **never** had a bad reaction.
- **What is your comfort level with Cannabis /Medical Marijauana**
- ( ) Very comfortable/ very knowledgeable
- ( ) Somewhat comfortable/somewhat knowledgeable
- ( ) Not very familiar
- ( ) Not at all familiar
- 
- 
- **CONSENT FOR TREATMENT AND MEDICAL CANNABIS USE**

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**I am being evaluated for a physician's recommendation for Medical Cannabis. The physician will make certification and recommendations based, in part, on the medical information I have provided. I hereby acknowledge that I have not misrepresented my medical condition to obtain this recommendation and it is my intent to use Medical Cannabis only as needed for the treatment of my medical condition, not for recreational or non- medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use, sale/purchase and/or distribution of Medical Cannabis.**

**By signing your full name below, you acknowledge you have read the consent/liability forms and you are giving your consent for treatment.**

**Print Name:** _____ **Date:**_____

***SIGNATURE:*** _____

(*) Required information

Please initial here:_____