Medical Intake

Information must be same as on Driver's License

Name_____ Cell #_____

Email _____

DOB _____SSN _____-_____-_____ Weight_____

Address_____

City_____ County _____ Zip_____

Medical Condition (check all that apply)

Cancer_☐_ HIV/AIDS_☐_ Epilepsy_☐_ PTSD_☐_ Glaucoma_☐_
Crohn"s_☐_ ALS_☐_ Parkinson's_☐_ MS_☐_ Anxiety_☐_
IBS_☐_ Arthritis_☐_ Lumbar Spine Dz_☐_ Cervical Spine Dz_☐_
Herniated Disc_☐_ Muscle Pain_☐_ Fibromyalgia_☐_
Other_____

Symptoms

Pain_☐_ Stiffness_☐_ Numbness/tingling_☐_ Muscle Cramps_☐_ Weight Loss_☐_
Back Pain_☐_ Arm/Leg pain_☐_ Sensory Loss_☐_ Headache_☐_ Decreased Appetite_☐_
Anxious_☐_ Depressed_☐_ Sleep Issues_☐_ Irritable_☐_
Abdominal Pain_☐_ Cramping_☐_ Nausea_☐_ Diarrhea_☐_ Constipation_☐_
Other_____

Medications (list all)

_____

_____

Social History (check yes or no)

Tobacco yes_☐_ no_☐_ Alcohol yes_☐_ no_☐_ How often_____ Illicit drugs yes_☐_ no_☐_

Plan (check all preferences)

Vape/Inhalation_☐_ Oral/sublingual (capsules and oil) _☐_ Topical (patches and lotions/gels)_☐_

Smokable (Flower)-state limit 2.5ounces every 35 days_☐_