Greenleaf Care
*the natural choice*



**PATIENT INFORMATION QUESTIONNAIRE**

**PATIENT INFO:** Today's date___/___/___

Last name: _____ First name: _____ MI _____ Date of birth___/___/___

Age:_____ Ht: _____ Wt: _____ Lbs: ☐ Male ☐ Female Occupation _____

Address: _____ City: _____ St. _____ Zip: _____

E-mail address: _____ ☐ Do not send me Medical Cannabis news letter

Home phone: _____ Cell phone: _____ Work phone: _____

Do you have insurance?: ☐ No: ☐ Yes: _____

Do you have a primary care physician?: ☐ No: ☐ Yes: _____

Have you been evaluated for Medical Cannabis before?: ☐ No: ☐ Yes: When?: _____

Why? _____ Name of Doctor? _____

How did you hear about us? _____

**MEDICAL HISTORY:**

**Medical Complaints:** (List medical problems for which you use/would like to use Medical Cannabis.)

_____
_____
_____
_____
_____
_____

Have you discussed any of these complaints with a medical care provider? (Include doctors, chiropractors, psychologist, acupuncturists, etc.)

☐ No ☐ Yes When? _____ Who? _____

Do you have records? ☐ No ☐ Yes

When did you last see your medical care provider? _____

**Medications:** (list all prescriptions and OTC medications you have taken for your medical complaints)

_____
_____
_____
_____
_____

**Other Treatments:** (check any treatments you use or have used for your medical complaints)

☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Massage
☐ Herbal Therapy ☐ Counseling ☐ Exercise ☐Other: _____

_____

**Past Medical History:** (check any condition(s) you have now or have had in the past)

☐ Asthma ☐ Diabetes ☐ HIV or AIDS ☐ Hypertension or High BP
☐ Cancer ☐ Hepatitis ☐ Stroke or CVA ☐ Multiple Sclerosis
☐ ADHD/ADD ☐ Alcoholism ☐ Heart Disease ☐ Intestinal Disorders
☐ Insomnia ☐ Weight Loss ☐ Kidney Disease ☐ Psychiatric Disorders
☐ Fibromyalgia
☐ Other_____

**Female Patients Only:** (check any condition(s) you have now or have had in the past)

Are you pregnant? ☐No ☐Yes Are you planning to get pregnant soon? ☐No ☐Yes

Are you breast feeding? ☐No ☐Yes Are you using contraception? ☐No ☐Yes

**Surgical History:** (list all surgeries you have had and any surgeries you may have scheduled now)

_____

**Drug and Alcohol use History:**

☐ Do you use tobacco? ☐ No ☐ Yes How much? _____
☐ Do you drink alcohol? ☐ No ☐ Yes How much? _____
☐ Have you ever been in drug rehab? ☐ No ☐ Yes How much? _____
☐ Do you ever use non-prescribed drugs? ☐ No ☐ Yes (please check below)
☐ Cocaine ☐ Methamphetamine ☐ Heroin ☐ Other _____

**Marijuana History:**

Do you currently use Marijuana? ☐ No **(skip section)** ☐ Yes (continue below)

How often? ☐ Every day ☐ Few times a week ☐ Few times a month

How used? ☐ Smoke ☐ Vaporize ☐ Ingest ☐ Topical ☐ Sublingual

How effective is it for your medical problems ☐ Very ☐ Moderately ☐ Minimal

Does it reduce or eliminate the need for medications? ☐ No ☐ Yes

List medications:_____

Does Marijuana use improve your quality of life? ☐ No ☐ Yes

Does it give any adverse side effects or problems? ☐ No ☐ Yes What kind?_____

_____

**Additional Information:**

Do you have any medications allergies? ☐ No ☐ Yes _____

Have you any open marijuana court cases? ☐ No ☐ Yes _____

Are you currently on probation? ☐ No ☐ Yes _____

Is there any additional information relevant to your examination today? _____

_____

I understand that the information I have been asked to provide is to help the physician to address the condition(s) for which I am here today. And I understand that if I have not accurately disclosed the requested information, it may adversely impact the physicians ability to make appropriate recommendations. I certify that the information in this questionnaire is accurate and complete.

I certify that I have read this document and understand its declarations.

_____ ____/____ /____

Patient signature Date

_____

Print name

**MEDICAL MARIJUANA PATIENT DECLARATION**

I hereby declare that I have completely and truthfully disclosed all information regarding my medical condition(s) and attest that I do not intend to use my medical recommendation for the purpose of illegally obtaining, growing or distributing medical marijuana. I attest that I am not a member, employee or agent of any media or law enforcement agency. It is illegal to film or record in this office with video camera, cell phone or any other recording devices, be it still image, video or audio. This is a direct violation of HIPAA regulations and patient/ doctor confidentiality. I am aware that my recommendation can be revoked at any time and legal actions will be taken if I have perjured or misrepresented myself or my medical condition, my intentions or falsified any medical records to the physician. I also herby authorize Greenleaf Care (GLC), or its representatives to discuss my medical condition(s) for verification purposes only.

Additionally, I acknowledge the attending physician informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana. The risks, complications and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge the attending physician informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and their risks and benefits. The physician may request that I visit another physician or specialist to further substantiate my condition. I will be informed of all the above mentioned regardless of whether or not I qualify as a patient.

PATIENT NAME (PRINT) _____ DATE: _____

PATIENT SIGNATURE: _____ PHONE: _____

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL RECORDS**

___ I hereby authorize (GLC) to disclose and verify my records as a patient to law enforcement should I be arrested or detained. I understand that (GLC) will only verify my being a patient for the purpose of providing proof as justification for possession. This is valid during the period of time for which the recommendation has been issued.

___ I hereby authorize (GLC) to disclose and verify my records as a patient to marijuana dispensaries/co-op for the purpose of obtaining medicine. This is valid during the period of time for which the recommendation has been issued.

___ I give permission for my medical records and file to be reviewed by another physician working with (GLC) I understand this might happen if the original doctor that evaluated me needs a secondary opinion, is not available, off premise, has moved or terminated his/her practice.

**Medical Marijuana Acknowledgements, Agreements, Disclosures and Informed Consent**

Please read each item below and initial in the space provided to indicate that you understand and agree to each item. By initialing, you understand and agree to the information disclosed. If you have any questions or do not understand the information below, consult with the attending physician before initializing or signing this agreement. Please do not sign this agreement and do not use marijuana if you do not understand the information you have received.

I, _____, (Patients Name), understand that medical marijuana is a medicine used in treating the suffering caused by serious and debilitating medical conditions. Serious and debilitating medical conditions include: Cancer, HIV, Nausea, Arthritis, Chronic Pain, Glaucoma, Cachexia, Migraines, Anorexia, Seizures, and persistent muscle spasms. Additionally, medical marijuana is used in the treatment of other chronic or persistent medical symptoms that:

- Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336)
- Other conditions for which marijuana provides relief
- If not alleviated, may cause harm to the patient's safety or physical or mental health

**Patient agrees by initialing the following:**

_____ I have been advised that the use of medical marijuana may affect my coordination, motor skills and cognition in ways that could impair my ability to drive and agree not to operate heavy machinery or to drive motor vehicles.

_____ I understand that side effects may occur while I am taking medical marijuana. Side effects of medical marijuana can include but are not limited to: Euphoria, difficulty in completing tasks, low blood pressure, sedation, dysphoria, dizziness, anxiety, confusion, impairment of motor skills, paranoia and overeating.

_____ I understand that my initial fee allows me free unlimited visits for 1 calendar year.

_____ I understand that chronic use of marijuana can lead to laryngitis, bronchitis, and general apathy.

_____ I understand the attending physician, staff and or representatives of GreenLeaf Clinics (GLC) are neither providing, dispensing nor encouraging me to obtain medical marijuana. I also acknowledge that the attending physician, staff and or representatives of GLC will not be providing or discussing information regarding dispensary, co-op, delivery service or any other way to obtain marijuana.

_____ I understand some users might develop a tolerance to marijuana. This means higher and higher doses are required to achieve the same benefit. It is recommended for patients to have an intermission with the drug for at least 3 weeks every 3-4 months. If I think I may be developing a tolerance to marijuana, I will notify the attending physician.

_____ I understand the benefits and risks associated with the use of marijuana are not fully understood and the use of marijuana may involve risks that have not been identified. I accept such risk.

_____ I agree that if I am a female patient that I will contact my attending physician if I become or am thinking about becoming pregnant. I acknowledge that the use of medical marijuana creates pass through problems to a fetus during pregnancy and to a baby during breast feeding.

_____ I understand that using marijuana while under the influence of alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.

_____ I should not be driving a vehicle while using marijuana and that I can get a DUI for driving under the influence.

_____ I am not permitted to smoke within 1000 feet of a day care or school. If I reside near those institutions I must use my medicine within the privacy of my own home.

_____ I agree to follow up with the attending physician at GLC with supporting medical records pertaining to my medical condition.

_____ I certify that I have read this document and acknowledge that my manipulation, alteration or falsification of this form, the GLC letter of recommendation, will result in the immediate termination of any legal right to my use of medical marijuana. Furthermore, GLC will report any of the above mentioned activities to local authorities.

_____ The physician, staff and representatives of GLC are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physicians/provider. Furthermore, the undersigned , my heirs, assigns, or anyone else acting on my behalf, hold the physician and his principals, agents and employees, free of and harmless from any responsibility for any harm resulting to me and/or other individuals as a result of my medical marijuana use.

I certify that I have read this document and understand its declarations.

_____ _____

Patient signature Date

**ATTENDING PHYSICIAN PLEASE SIGN BELOW:**

I have asked the patient if he/she has any questions regarding his/her treatment with medical marijuana.

I have answered those questions to the best of my ability.

PHYSICIAN SIGNATURE: _____ DATE: _____

**RELEASE OF LIABILITY**

I understand that I must be a California or Michigan Resident to obtain an approval or recommendation for the use of cannabis (medical marijuana) under California's Compassionate Use Act of 1996 (Health and Safety Code #11362.5) and the Michigan Medical Marihuana Program (MMMP) which is established to administer the registration program provided for in the Michigan Medical Marihuana Act (MMMA), which was approved by Michigan voters on November 4, 2008.

I affirm that I have a serious medical condition that adversely affects my quality of life. I have found or am interested in finding whether cannabis provides substantial relief and improvement in my condition.

I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities and/or contaminates. In requesting an approval or recommendation for the use of this plant as medication I assume full responsibility for any and all risk of this action.

I am advised that the cannabis smoke contains chemicals known as tars that may be harmful to my health. Recent research indicated that vaporizing cannabis might eliminate exposure to tar. Should respiratory problems or other ill effects be experienced in association with its use, it should be discontinued and reported to a physician.

I am advised that the use of cannabis may affect my coordination and cognition in ways that could impair my ability to drive, operate heavy machinery, or engage in potentially hazardous activities. I assume full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis.

California's Compassionate Use Act of 1996 (Health and Safety Code #11362.5) and the Michigan Medical Marihuana Program (MMMP) provides for the possession and cultivation of cannabis for the personal medical purposes of a patient with a physician approval or recommendation. It should be made absolutely clear that the physician, staff, management and representatives of this practice are neither providing cannabis, nor are they encouraging any illegal activity in my obtaining cannabis.

I, the undersigned, hereby request a consultation by a physician for purposes of determining the appropriateness of medical cannabis treatment. There are no claims about the medical efficacy of cannabis. The physician, staff, management and representatives of this practice are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care provider. Should an approval be made for my medical use of cannabis, I understand that there is an expiration of this approval at a date specified by the physician. I understand that it is my responsibility to see a physician to assess the possible continuance of cannabis use beyond the approval expiration date. Furthermore, I, the undersigned, my heirs, or anyone acting on my behalf, hold the physician and his/her principals, agents, employees and management, harmless and free from any liability resulting from the use of cannabis.

If anything changes with my medical condition I will notify GreenLeaf Care immediately.

I understand that GLC may be contacted to verify the information contained in my physician's letter of recommendation. I hereby authorize the staff of GLC to discuss my medical condition and the contents of my physician's letter of recommendation for verification purposes.

_____ _____

Patient signature Date

_____

Print name

AFFIDAVIT

I acknowledge and testify under penalty of perjury under California & Michigan law, that I am not working, nor have I ever worked for a federal law enforcement agency (e.g., the DEA, FBI, CIA, FDA, or AFT).

I state as fact that I am not an undercover officer representing any of the aforementioned agencies. I testify as fact that I am not here to entrap or gather evidence for a local, state, or federal agency. I do not work for, nor represent in any way, any local, state, or federal law enforcement agency.

The purpose of my visit is to obtain a personal and private consultation and evaluation of medicinal cannabis that I feel may benefit my medical condition. If I am approved to use medical cannabis, I swear I will not cultivate or distribute medicinal marijuana outside the confines of the law.

Understood and agreed,

_____ _____

Patient signature Date

**Physician's Notes**

Patient Name: _____ D.O.B. _____

Subjective: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Objective: ☐ Alert Lucid & Oriented ☐ Heart Regular Rhythm ☐ Lungs Clear ☐ Gait Normal

_____

_____

_____

Viewed: Documents: _____

Prescriptions: _____

_____

Assessment: _____ Plan _____

☐ Chronic pain due to _____
☐ Chronic Migraines _____
☐ Chronic Anxiety _____
☐ Chronic Depression _____
☐ Chronic Insomnia _____
☐ Post Traumatic stress Disorder _____
☐ ADD OR ADHD _____
☐ _____
☐ _____

Physician signature:

☐ No recommendation letter given for Cannabis
☐ 3 month recommendation letter given for Cannabis
- ☐ Need physician notes
- ☐ Need physician visit & notes
- ☐ List of community clinics were given to patient

☐ 12 month recommendation letter given for Cannabis

**Follow-up:**
☐ 1 month ☐ 3 month ☐ 6 month ☐ 12 months

**Deliver methods recommended:**
☐ Vaporizer ☐ Sublinguel ☐ Topical
☐ Ingestion (warned of dosing issues related to delay in onset of action)

**Discussed major effects of major strains of Cannabis:**
☐ Sativa / Sativa Dominant Hybrid recommended
☐ Indica / Indica Dominant Hybrid recommenced

**Discussed appropriate safe and legal use of Cannabis:**