Marijuana Certifications

Phone (213) 542-0665

Scottsdale, AZ

Health Questionnaire

Personal Information:

Name_____ DOB_____ Date_____

Age_____ Height_____ Weight_____ Gender: Male/Female

Medical History

Current medical complaint: (List the medical problem(s) for which you use or would like to use medical marijuana; include year of onset of symptoms)

_____
_____
_____
_____

Primary Care Provider or Specialist: Please give the name of your health care provider or Specialist (including chiropractor, psychologist/acupuncturist, etc.) that you've seen related to your chief complaint:

_____
_____
_____

Medications: List all of your medication (include prescription and over-the-counter)

_____
_____
_____
_____

List any medications that you are allergic to:

_____
_____

Health Questionnaire Cont.

Check any treatments you have tried currently or in the past for your condition:

____surgery ____physical therapy ____chiropractic ____massage ____Rx Meds ____OTC Meds

____injections ____exercise ____acupuncture ____ ice ____heat ____topical

____aromatherapy other:_____

Do you have or have you ever been diagnosed with the following medical conditions?

____Asthma/Lung Disease ____Cancer

____HIV/AIDS ____Diabetes

____Hepatitis ____Epilepsy/Seizures

____Stroke ____Liver Disease

____Kidney Disease ____High Blood Pressure

____Heart Disease ____Sleep Disorders (sleep apnea, insomnia)

____Substance Abuse ____Intestinal Disorders (IBS, Ulcers)

____Multiple Sclerosis ____Psychiatric Disorders (depression, anxiety, etc.)

____ADD/ADHD

Female Patients Only

Are you pregnant? Yes/No Are you currently nursing? Yes/No

Surgical History

Please list the surgeries that you have had including dates

_____
_____
_____

Drug and Alcohol History

Do you currently use: Tobacco? Yes/No Number of cigarettes per day _____

Alcohol ? Yes/No Number of drinks per week _____

_____
_____

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Do you use marijuana to reduce or eliminate the use of any medications that have been prescribed for your medical condition? Yes/No

If yes, which medication have you reduced or eliminated and why?

_____

_____

How often do you use marijuana?
( ) every day or almost everyday
( ) about 1-2 times per week
( ) more than once per month

What is your preferred method of using marijuana?
( ) smoke
( ) vaporizer
( ) ingested
( ) topical

How effective is marijuana for your medical problem?
( ) very effective
( ) effective
( ) only somewhat effective

How does marijuana improve the quality of your life?

_____

_____

Please provide any additional information that may be relevant to the physician evaluation:

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_____ I acknowledge that after completion of the certification process and Marijuana Certifications has submitted my application with final payment made to the Arizona Department of Health, it will be my responsibility to obtain refunds for the state fee if I decide not to obtain the Medical Card.

_____ I acknowledge that marijuana, even if it is used for medical purposes, is illegal under Federal law and has been placed on Schedule 1 by the US FDA. As such, marijuana is considered to have no medical benefit and a significant potential for abuse. I assume all responsibility for any violation of Federal law.

_____ _____
Patient Signature Date

_____
Print Name

_____

I understand that the information I have been asked to provide is for the diagnosis and treatment of the medical condition for which I am seeing the physician today and, if I have not accurately and completely disclosed the requested information, it may adversely impact the physician's ability to diagnose my condition and recommend appropriate treatment. I certify that I am not seeking marijuana for illegal purposes; I am not a reporter or member of the media working on a story; and I am not a member of law enforcement seeking to investigate or build a case against my physician or anyone affiliated with my physician.

_____ _____
Patient Signature Date

_____
Print Name

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Informed Consent and Release from Liability

I am being evaluated for a physician's recommendation for medical marijuana. The physician will make this recommendation based, in part, on the medical information I have provided. I have not misrepresented my medical condition in order to obtain this recommendation and it is my intent to use marijuana 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 marijuana.**

1. I must be an Arizona resident and over 18 years of age to obtain an approval or recommendation for the use of cannabis (medical marijuana) under Arizona law. If I am under 18 years of age I must have a parental consent and authorization for the use of medical marijuana.

2. The federal government has classified marijuana as a Schedule 1 controlled substance. Schedule 1 Substances are defined, in part, as having (1) a high potential for abuse; (2) not currently accepted medical use in treatment in the United States; and (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of marijuana even in states such as Arizona, which have modified their state laws to treat marijuana as a medicine.

3. Marijuana has not been approved by the Food and Drug Administration for marketing as a drug. Therefore, the "manufacture" of marijuana for medical use is not subject to any standards, quality control, or the oversight. Marijuana may contain unknown quantities of active ingredients (i.e., can vary in potency), impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

4. The use of marijuana can affect coordination, motor skills and cognition, i.e., the ability to think, judge, and reason. While using marijuana, I should not drive, operate heavy machinery or engage in any activities that require me to be alert and/or respond quickly. I understand that if I drive while under the influence of marijuana, I can be arrested for "driving under the influence".

5. Potential **side effects** from the use of marijuana include, but are not limited to the following:

Dizziness, anxiety, confusion, sedation, low blood pressure, impairment of short-term memory, euphoria difficulty in completing complex tasks, suppression of the body's immune system, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Marijuana may increase eating, alter my perception of time and space and impair my judgment.

6. 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.

7. I agree to contact the emergency room/urgent care if I experience any of the side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. I will also contact the emergency room/urgent care if I experience respiratory problems, changes in my normal sleeping patterns and extreme fatigue increased irritability, or begin to withdraw from my family and/or friends.

8. Smoking marijuana may cause respiratory problems and harm, including bronchitis, emphysema and laryngitis. In the opinion of many researchers, marijuana smoke contains known carcinogens (chemicals that can cause cancer) and smoking marijuana may increase the risk of respiratory disease and cancers in the lung, mouth, and tongue. In addition, marijuana smoke contains harmful chemicals known as tars. If I begin to experience respiratory problems when using marijuana, I will stop using it and report my symptoms to a physician.

9. The risks, benefits and drug interactions of marijuana are not fully understood. If I am taking medications or undergoing treatment for any medical condition, I understand that I should consult with my treating physician(s) before using marijuana and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating physician(s).

10. Individuals may develop a tolerance to, and/or dependence on, marijuana. I understand that if I require increasingly higher doses to achieve the same benefit or if I think that I may be developing a dependency on marijuana, I should contact Marijuana Certifications.

11. Signs of withdrawal can include: Feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

12. Symptoms of marijuana overdose include, but are not limited to nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in the hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to go to the nearest emergency room.

13. If Marijuana Certifications subsequently learns that the information I have furnished is false or misleading, the recommendation for marijuana may no longer be valid. I agree to promptly meet with Marijuana Certifications' Physician and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided.

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Release and Hold Harmless

I acknowledge the Marijuana Certifications' physician informed me of the nature of a recommended treatment, including but not limited to recommendations regarding medical marijuana. The Marijuana Certifications' physician also informed me of the risks, complications and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge the Marijuana Certifications' physician informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and the risks and benefits when applicable.

Furthermore, I, the undersigned (including my heirs, or anyone acting on my behalf), hold Marijuana Certifications, the physician and his/her principals, agents, employees and management, harmless and release them from any liability resulting in any way whatsoever from my use of marijuana. This release of liability includes, but is not limited to, any bodily or psychological injury, whether known or unknown, as well as legal and/or employment problems resulting from my use of marijuana.

_____ _____

Patient Signature Date

_____

Patient Name

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Patient Acknowledgement

I Understand that: (**Initials**:)

_____ The attending physician, staff and or representatives of Marijuana Certifications are neither providing, dispensing nor encouraging me to obtain medical marijuana.

_____ The physician, staff and representative of Marijuana Certifications are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider.

_____ An approved medical card is only valid for two years and renewal will be required by the patient before the expiration date.

_____ I acknowledge that I am a resident of Arizona, I am at least 18 years of age and have not misrepresented any information to Marijuana Certifications.

_____ I acknowledge that I am not an agent of law enforcement, state, or federal government here for the purpose of investigation or entrapment.

_____ I acknowledge that I am not recording any portion of my visit with Marijuana Certifications, nor do I possess any recording equipment. I understand Marijuana Certifications does not approve of such action. I further acknowledge that, without express written permission of Marijuana Certifications, it is illegal to film or record in this office with video cameras, cell phones or any other recording devices, including still image, video or audio. Any such action is a direct violation of HIPAA regulations and patient/doctor confidentiality.

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

MARIJUANA PROGRAM PATIENT ATTESTATION

I, _____ , attest that:

print here

I will not divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant A.R.S. Title 36, Chapter 28.1 and that the information provided in the application is true and correct.

_____ _____

Signature Date Signed

NAME DOB: DATE:

Please olace a cheek (,/) in the box that best describes you:

SOCIAL HISTORY	Heavy	Moderate	light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	D	D
Tobacco	D	☐	D	D
Recreational drugs	D	D	D	D
Exercise	D	D	D	D
Sleep	☐	D	**D**	☐
Appetite	☐	☐	D	☐

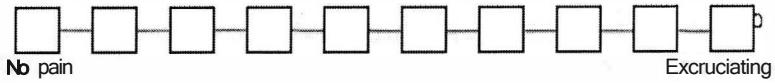
Please place a check(,/) in the box that **best** describes the effects of your current condition on daily activities:

ACTIVIT	No effecl	Pain		No effect	Pain
Bending	☐	☐	Household chores	☐	☐
Carrying groceries	☐	☐	liffing	☐	☐
Sit to stand	D	☐	Pet care	☐	☐
Climbing **stairs**	D	☐	Self care	☐	☐
Driving	☐	☐	Walking	☐	☐
Using the computer	☐	☐			

Is there any other information about your health history that we should **be** aware of? Please explain.

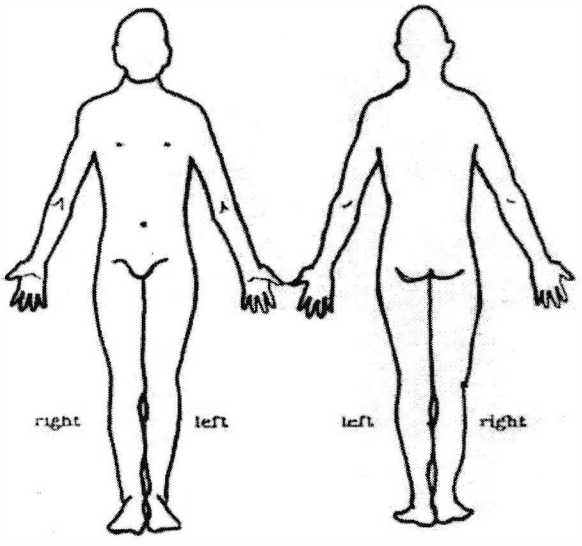
Have you sought treatment from another doctor? ___ If yes, please provide a **brief** explanation,

Mark on the pain scale from 0 to 10 the pain you feel:



Draw the appropriate symbol(s) on the body of where you feel the **MOST** pain:

Numbness	pins & needles	burning	aching	stabbing
___	000	XXX	* * "	///



Return When Complete

How did you hear about us? (please circle one)

Returning Patient Google Signage Other_____
Friend/Family **REFERRAL** _____ Dispensary _____

THE FOLLOWING INFORMATION IS NECESSARY FOR THE APPLICATION PROCESS AND MUST BE ACCURATE

First Name _____ Last Name _____ Suffix _____

Gender (circle): Male or Female Date of Birth: _____/_____/_____

Phone: (____) _____-_____ Email: (print clearly)_____

Address: _____**Apt/Unit #_____**

City _____ State _____ County _____ Zip _____

Mailing Address (IF DIFFERENT FROM ABOVE):

Address: _____**Apt/Unit #_____**

City _____ State _____ County _____ Zip _____

IMPORTANT:
The State now requires that applications be sent through the patient portal on the individual licensing portal.
We have to pay a third party to process uploads. You have the option to do your own upload or choose to have them do it (strongly recommended as its difficult and errors delay getting to your card). We don't know how to do the uploads this way and they are too busy doing uploads to aid you. When you make your portal and want the third party to do them, we need you to legibly print your log in below. If you want a laminate, text us to let us know you are approved and we'll log in to get your card, if you change your password, you have to email the file to us. Google individual licensing portal to make your log in.

Have the 3rd party do the upload for $20? No Yes

Portal Email: Password:

Do you want to send us the pdf file of your card and have us laminate it for $20? No Yes

Caregiver (Circle): NO YES Name:_____

Cultivate (Circle: NO YES (excluding felonies/misdemeanors do NOT allow a patient to cultivate.

All patients must live outside 25 miles from a dispensary per AZPROP 203 to cultivate).

Food Stamp Participants (Circle): NO YES

Print Name: _____ Signature: _____

Date: _____