ALTERNATIVE WELLNESS CENTERS

for the mind, body and soul

Date: ____________________

Name: ____ Age: ________

Address: ________________________________ City: ______________ State: _____

Phone: ____________________ Email: ____

DOB: ______________________ Last 4 Digits of SSN: ____________________________

Emergency Contact: ____________________________ Phone: ____________________

Please check off the reason you are here today for Cannabis:

☐ Cancer:
What kind? ____________________________
How long? ____________________________
☐ Glaucoma
☐ HIV/AIDS
☐ Hepatitis C
☐ Depression
☐ Severe Pain:
Location ______________________________
Duration?______________________________
Describe the pain _______________________
If you have pain, how bad does it get on a scale of 0-10? (10 being the worst) ______________

☐ Severe Nausea: How often?
____
☐ Seizures
☐ Multiple Sclerosis
☐ Arthritis
☐ PTSD
☐ Anxiety Disorder
☐ Insomnia
☐ Migraines
☐ IBS/Crohn's/Colitis
☐ Other:
____

How does this medical condition interfere with your daily life? (work, eat, sleep, social interaction, etc.)

Please explain: ____

____

Was the condition a result of an injury? ☐ Yes ☐ No Type of Injury: ______________________________

Do you currently use cannabis to treat your condition(s)? ☐ Yes ☐ No

If yes, how is it helping you? ____

When did you discover that cannabis helped with your symptoms? ______________________________

What medications are you prescribed?
____
____
____
____

Over the Counter/Herbal
____
____
____
____

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Past Medical History: ____

____

☐ Diabetes

☐ High Blood Pressure

☐ Asthma COPD or Lung Disease

☐ Stomach or Abdominal problems

☐ Muscle cramps

☐ Headaches

☐ Heart Disease

☐ Allergies to any medication?

Name(s)

____

____

Injuries: ____

Surgeries: ____

During the past month, have you felt tense or anxious? ☐ Yes ☐ No

During the past month, have you felt depressed or discouraged? ☐ Yes ☐ No

During the past month, have you been upset or irritable? ☐ Yes ☐ No

Are you currently employed? ☐ Yes ☐ No

If yes, what kind of work do you do? ______________________________

Are you currently on disability? ☐ Yes ☐ No

Do you smoke tobacco? ☐ Yes ☐ No How much/how often? ______________________

Do you drink alcohol? ☐ Yes ☐ No How much? __________ How often? ______________

Do you have a history of drug abuse? ☐ Yes ☐ No

Do you have a personal history of psychosis? ☐ Yes ☐ No

How did you hear about Alternative Wellness Centers?

☐ Google ☐ Friend ☐ Other______________________