

Welcome to

# Compassionate Health Options

Date \_\_\_\_\_

Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt. No. \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

California ID number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Sex:  Male  Female  Transgender  Transsexual  Decline to state

Ethnicity: African-American/Asian/Latino/Native American/Caucasian/Pacific Island/ Other

Do you have health insurance? Y N If yes, what kind? \_\_\_\_\_

Primary care doctor or clinic. Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Other consultants/specialists: \_\_\_\_\_ Phone \_\_\_\_\_

I hereby request a medical evaluation for the purpose of receiving a recommendation or approval to use cannabis for relief of certain symptoms as documented by history, physical examination and medical records, under California Health and Safety code SSI 11362.5.

I understand the doctors of Compassionate Health Options (herein referred to as CHO) reserve the right to refuse services to anyone and that completing this application does not (automatically) guarantee their approval/recommendation.

I understand that the doctors of CHO are NOT my primary care physicians; they will not assume any role beyond counseling and issuing an approval/recommendation if they believe one is indicated. Monitoring and supervision of my health care is my own responsibility in conjunction with my personal physician and/or other health care provider.

Any unauthorized release of information in this record is forbidden under federal HIPAA laws. By providing my approval/recommendation to a third party, I have authorized confirmation of the following information: name, date seen, date of birth, date of expiration, and diagnosis.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Patients Under 18:**

Parent/Legal Guardian: Print Name \_\_\_\_\_

Parent's signature: \_\_\_\_\_ date \_\_\_\_\_



OVER

## Patient Agreements/Consent To Use Medical Marijuana

I, \_\_\_\_\_ am requesting permission for the use of medical marijuana under California's Compassionate Use Act (SB420), and in doing so assume full responsibility for any and all risks of this action related to my current medical condition.

I assume full responsibility for my actions and I, my heirs, assigns, or anyone acting on my behalf, hold the physician and his/her principles, agents, and employees free of and harmless from any responsibility for any harm resulting to me and or anyone else as a result of my cannabis use.

I understand that under the Controlled Substance Act of 1970 cannabis is categorized Schedule I, defining it as highly addictive and having potential for abuse; it may contain unknown quantities of active ingredients and/or other impurities.

I acknowledge that I have been advised not to drive vehicles, operate machinery, or participate in any activity that requires safe judgment or analytical abilities while under the influence of cannabis.

I understand that there are potential risks combining alcohol/other substances and certain medications along with cannabis. I assume any such risks and responsibilities and will discontinue cannabis use if I notice any unwanted symptoms or side effects. These side effects can include, but are not limited to: nausea, lethargy, upper respiratory problems, difficulty with short term memory, anxiety, headaches, paranoia, loss of coordination, psychological dependence on cannabis.

I understand that I must be a California State resident to receive a medical marijuana recommendation, and I have provided my physician with a current California driver's license or I.D. card (issued by the state) to be photocopied and placed in my medical chart. If I do not have a California I.D. card, I will provide another state issued I.D. or passport and proof of California residency.

I understand that the recommendation form expires on the date specified at the time of the recommendation. I understand that it is my responsibility to see my physician to assess the possible continuance of medical marijuana use beyond the expiration of the recommendation.

I hereby give consent for the physicians of Compassionate Health Options at his/her discretion, to affirm the signing of the medical cannabis recommendation form.

I am over eighteen (18) years old or have the written consent of my parent/legal guardian.

**I declare under the penalty of perjury, that all of the information on this form is true and accurate:**

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Patient's Signature

Date

# Patient History (page 1 of 3)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

**What are the main problems or symptoms for which you seek an evaluation today?** Please list and describe these in detail, (e.g., pain, nausea, anxiety, etc.) including when/why they started:

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**Circle the number which best describes how these symptoms interfere with your life:**

<b>work</b>	0 1 2 3 4 5 6 7 8 9 10 not at all completely	<b>relationships</b>	0 1 2 3 4 5 6 7 8 9 10 not at all completely
<b>sleep</b>	0 1 2 3 4 5 6 7 8 9 10 not at all completely	<b>physical activity</b>	0 1 2 3 4 5 6 7 8 9 10 not at all completely
<b>mood</b>	0 1 2 3 4 5 6 7 8 9 10 not at all completely	<b>enjoyment of life</b>	0 1 2 3 4 5 6 7 8 9 10 not at all completely

**When was your last medical visit to a doctor/chiropractor etc.?** \_\_\_\_\_ **What did you see this provider for?** \_\_\_\_\_

**Are you currently pregnant?** Yes  No  **Are you currently breastfeeding?** Yes  No

**Have you talked to your primary care doctor about medical cannabis?** Yes  No   
**If you haven't, why not?** \_\_\_\_\_

**Other medical illnesses:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Surgeries with dates:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Current and Previous Medications (include, herbs, OTC meds. etc.)

Medications & Dosage	Side Effects	Last Filled	Where Filled	RX#
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

## Current/Previous Treatments: check all that apply and give approximate dates

___chiropractor	___stretching	___massage therapy
___yoga	___vitamins	___physical therapy
___acupuncture	___exercise	___injections
___meditation	___counseling	which of these have helped you the most _____

# Patient History (Page 2 of 3)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

## Cannabis Use

Describe how cannabis relieves your symptom(s). If you have not used cannabis for your condition, why do you think it might be useful? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(check all that apply):

- decreasing pain     decreasing nausea     increasing appetite     improving/increasing sleep  
 decreasing anxiety/depression     improving overall sense of well/being     improving relationships  
 improving ability to work/function

Routes Tried  Inhaling (smoking, vaporizing)  Orally (edibles, tinctures)  Topical (ointments, oil)

Preferred Method of Medicating  Pipe  Water pipe/bong  Joint  Vaporizer  Blunt/spliff

Concentrates (hash oil, keif)  Edibles or tinctures

Quantity

What is the amount you currently use in grams or ounces per day/week/month? (e.g.: 1/8 per month)

Amount \_\_\_\_\_

How long have you been using cannabis? \_\_\_\_\_ Have you ever had a cannabis recommendation? Y  N

On average how many times do you medicate? Please indicate in the boxes below:

6am to 10am	10am to 2pm	2pm to 6pm	6pm to 10pm	10pm to 2am	2am to 6am

## Smoking

Do you smoke cigarettes? Y  N

If yes, what age did you start? \_\_\_\_\_ How much do you smoke a day? \_\_\_\_\_

Have you ever tried to quit smoking? Y  N  When? \_\_\_\_\_ How? \_\_\_\_\_

## Drinking

Do you consume alcoholic beverages? Y  N

How many drinks do you consume a Day? \_\_\_\_\_ Week? \_\_\_\_\_ Month? \_\_\_\_\_

Have you ever had a problem drinking too much alcohol? Y  N  When? \_\_\_\_\_

Have you ever attended Alcoholics Anonymous or a similar program? Y  N

Give details: \_\_\_\_\_

## Arrest/Criminal History

Have you ever been arrested Y  N  If so give details \_\_\_\_\_

I have no criminal record

## Other Drug Use

Are you currently using or did you in the past use any of the following drugs?

Cocaine Y  N  Amphetamines/Crank Y  N  Opiates Y  N  LSD/Acid Y  N

Ecstasy Y  N  Downers/Pills Y  N  Mushrooms Y  N  Ketamine/GHB Y  N

When and for how long did you use any of these? \_\_\_\_\_

# Patient History (Page 3 of 3)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

## Family Medical History

In your family, has there been a history of: (check all that apply)

heart disease  high blood pressure  cancer  diabetes  arthritis  depression  alcohol/drug abuse  other \_\_\_\_\_

Is your mother alive?  Yes  No If no, when did she die? \_\_\_\_\_ From what? \_\_\_\_\_

Is your father alive?  Yes  No If no, when did he die? \_\_\_\_\_ From what? \_\_\_\_\_

## Social History

### Current Living Situation

#### Apartment

Rent  Own

#### Condo

Rent  Own

#### House

Rent  Own

Shelter Institution

Homeless

Other \_\_\_\_\_

Whom do you live with? \_\_\_\_\_

Do they approve or your marijuana use or not?  yes  no

### What do you do for exercise?

walk  run  swim

sports \_\_\_\_\_

bike  other \_\_\_\_\_

How many times per week?  
\_\_\_\_\_

### Are you

Married how long \_\_\_\_\_

Partner of significant other

Single

### Sexual Orientation

Heterosexual

Homosexual

Bisexual \_\_\_\_\_

Other \_\_\_\_\_

Do you have any children? Yes  No

How old are they? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Whom do they live with \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you see them and how often? \_\_\_\_\_

### Employment

Employed

Occupation \_\_\_\_\_

For how long \_\_\_\_\_

Student (Where?) \_\_\_\_\_

Unemployed  Retired

Disabled  Worker's Comp

### On an average day how much do you consume of:

\_\_\_\_\_ meat \_\_\_\_\_ vegetables \_\_\_\_\_ fruit \_\_\_\_\_ whole grains

\_\_\_\_\_ refined grains (i.e., white bread, rice, flour etc.)

\_\_\_\_\_ coffee \_\_\_\_\_ soda

### Do you eat (check all that apply)

processed foods  fast food  junk food

### Have you ever experienced or been diagnosed with any of the following? (enter age or year on the line provided below)

ADD \_\_\_\_\_

Physical Abuse \_\_\_\_\_

ADHD \_\_\_\_\_

Emotional Abuse \_\_\_\_\_

School problems \_\_\_\_\_

Sexual Abuse \_\_\_\_\_

Depression \_\_\_\_\_

N/A

Behavior issues \_\_\_\_\_

If you were diagnosed with any of the above, did you take medications? If so, what and when? \_\_\_\_\_

## Childhood History

Who raised you? \_\_\_\_\_

If your parents didn't raise you, who did and why? \_\_\_\_\_

How many siblings do you have? \_\_\_\_\_

What grade did you complete in school? \_\_\_\_\_ If you did not complete high school, did you drop out, were you expelled, did you start working. etc? Please briefly describe your childhood and include anything else that you want us to know.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

**For Office Use Only**

B/P	Pulse	HT	WT	LNMP	G	P
<input type="checkbox"/> Normal organ system					Abnormal findings	
<b>General:</b>	<input type="checkbox"/> well developed/well nourished – alert					
<b>Skin:</b>	<input type="checkbox"/> intact...warm...dry...well hydrated...no rashes					
<b>HEENT:</b>	<input type="checkbox"/> External inspection nml...					
<b>Neck:</b>	<input type="checkbox"/> Non-tender – ROM w/o pain – no palpable masses					
<b>Resp:</b>	<input type="checkbox"/> nml resp. effort & excursion – breath sounds nml/equal/clear					
<b>CVS/chest:</b>	<input type="checkbox"/> RRR – no M/G/R – nml s1/s2					
<b>GI:</b>	<input type="checkbox"/> non distended – non-tender – no masses – no guarding – no rebound					
<b>Back:</b>	<input type="checkbox"/> no vertebral tenderness – no CVAT					
<b>Hips/Pelvis:</b>	<input type="checkbox"/> FROM ... non-tender					
<b>Extremities:</b>	<input type="checkbox"/> FROM ...normal extremities:					
<b>Lymph:</b>	<input type="checkbox"/> no lymphadenopathy: neck...axilla...groin					
<b>Neuro:</b>	<input type="checkbox"/> CN II-XII intact...DTR's symmetric...sensory nml...motor symmetric/ w/...leg raise neg.					
<b>Psych/Mini Mental status:</b>	<input type="checkbox"/> oriented x 3...mood appropriate...judgment good...nonsuicidal Done if needed: Date, place, register 3 Objects, Serial Sevens, Recall 3 Objects, etc.					
<b>Notes</b>	<hr/> <hr/> <hr/>					
<b>Assessment</b>	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
<b>Plan</b>	1. _____ 2. _____ 3. _____ 4. _____ 5. <input type="checkbox"/> Pt. to f/u with PMD for management, update of mental/physical conditions. 6. <input type="checkbox"/> Vaporizer/edibles etc. <input type="checkbox"/> R&B discussed <input type="checkbox"/> Medical Record release 7. <b>Cannabis approval for</b> <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 9 months <input type="checkbox"/> 12 months Other _____  Physician's Signature _____					