FRXHEALTH

Patient Intake Form

Last Name:_____ First Name:_____

DOB: _____/_____/_____ Sex: M / F Date of Consult_____

Address:_____

City:_____ State: __OH___ Zip:_____

Preferred Ph. # (home/cell/work):_____ Alt. Ph. #:_____

Email Address:_____

Do you have Health Insurance? ❑ Yes ❑ No Provider:_____

Registered Caregiver (if none, write n/a): _____

Caregiver Contact Information:_____

Emergency Contact Name:_____

Emerg. Contact Phone # / Relation to Patient:_____

Qualifying Condition(s) for Ohio Medical Marijuana Program:

- ☐ AIDS
- ☐ Amyotrophic Lateral Sclerosis
- ☐ Alzheimer's Disease
- ☐ Cancer (type)
- ☐ Chronic Traumatic Encephalopathy
- ☐ Crohn's Disease
- ☐ Epilepsy or other Seizure Disorder
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Hepatitis C
- ☐ Inflammatory Bowel Disease
- ☐ Multiple Sclerosis
- ☐ Pain that is either Chronic and Severe or Intractable
- ☐ Parkinson's Disease
- ☐ Positive for HIV
- ☐ Post Traumatic Stress Disorder
- ☐ Sickle Cell Anemia
- ☐ Spinal Cord Disease or Injury
- ☐ Tourette's Syndrome
- ☐ Traumatic Brain Injury
- ☐ Ulcerative Colitis

Concurrent Medical Diagnoses

DIAGNOSIS made by Health Care Provider: (make an X in front of disease (s))

	AIDS / HIV		Arthritis of:
	ADHD (attention deficit hyperactivity disorder)		Schizoaffective Disorder
	Asthma		Bipolar Disorder
	COPD		**Schizophrenia**
	Permanently disabled		Depression
	Diabetes w/ extremity pain or nausea		Migraine headaches
	Glaucoma		Stomach ulcers
	Heart disease		**Epilepsy / Seizures**
	High Blood Pressure		Amyotrophic Lateral Sclerosis (ALS)
	Stroke		Hepatitis: B or C
	Kidney disease		Multiple Sclerosis
	Muscle or Movement Disease		Parkinson's Disease
	Cancer of:		Other:

SYMPTOMS you are experiencing: (make an X in front of symptoms)

	Anxiety / Stress		Depressed feelings
	Pain, Joints; location:		Pain, Neck or Back
	Headaches		Muscle spasms; where:
	Vision problems/eye pain		Numbness or tingling in limbs
	Acid Reflux / Heartburn / Stomach Pain		Insomnia / Sleeping disorder
	Loss of appetite / Weight loss		Nausea / Vomiting
	Constipation (especially with medications)		Chronic Cough
	Dizziness		Urinary problems
	Skin Rash		Tremor
	Seizures/Convulsions		Other:

Do you consume Alcohol? ❑ no ❑ yes Number of drinks per week_____

Do you use Tobacco products? ❑ no ❑ yes Smoke/Chew Qty per day_____

Female patients: Are you pregnant? ❑ no ❑ yes Breastfeeding? ❑ no ❑ yes

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Are you currently taking any medications on a regular chronic basis? Check those that apply.

Prescription medication? ❑ no ❑ yes OTC medications? ❑ no ❑ yes

Herbal medications? ❑ no ❑ yes Vitamins & Minerals? ❑ no ❑ yes

Please list medications on next page: FRX HEALTH Medication Documentation Sheet

FRX HEALTH Medication Documentation Sheet (please include **ALL** prescription, OTC, vitamins, and herbal medications)	
Medication Name	Medication Name

Allergies (food, medication, ingredients, other):_____

_____

History of Marijuana Use (please circle): Never Used | Used in Past | Currently Using

Describe Use (please circle): Mostly Medical | Mostly Recreational | Both Med and Rec

Used approximately how long?_____

Dosage Forms Used:

☐ Smoked Flower ☐ Edible Products ☐ Tinctures ☐ Other (please list below)
☐ Vaporized Flower ☐ Capsules/Tablets ☐ Sublingual Sprays
☐ Vaporized Oil ☐ Liquids/Drinks ☐ Transdermal Patches
☐ Concentrates ☐ Homemade Edibles ☐ Lotions/Topicals _____

History of Adverse Reactions to Marijuana?_____

Did your physician place restrictions on your Medical Marijuana? ❑ Yes ❑ No Explain:_____

Goals of Therapy with Medical Marijuana:_____

_____

Any special needs required by patient?_____

How do you prefer to be contacted? (please circle) Phone | Text | Email | No Preference

Do you care to receive marketing correspondence from FRX HEALTH? ❑ Yes ❑ No

How did you choose FRX HEALTH? (check all that apply):

☐ Physician ☐ Social Media ☐ Family / Friend Referral ☐ Other:

Thank you for choosing FRX HEALTH. We appreciate your information.
Please note, this information will NOT be shared with other parties without your consent.

We look forward to providing you with safe access to Ohio Medical Marijuana.