COMPLETED BY:

Patient Intake Form

Name:	**Date:**
Mailing Address:	
Date of Birth:	**Current Age:**
Email:	**Phone:**

Medical History

Are you currently taking any medications (including Over the Counter Medications)?

- ☐ **Yes**
- ☐ **No**

If yes, list medications: _____

If you have been prescribed medications in the past or if it was suggested you take any medications in the past, please list them here. If you do not remember the names, please state or check what they were prescribed/suggested to treat: _____

- ☐ **Opioids**
- ☐ **Pain Medication**
- ☐ **Antidepressants**
- ☐ **Sleep Medication**
- ☐ **Antianxiety Medication**
- ☐ **ADHD or ADD Medication**
- ☐ **NSAIDS**
- ☐ **Antipsychotics**

Are you allergic to any medications?

- ☐ **Yes**
- ☐ **No**

If yes, list allergies: _____

List any surgical procedures with estimated dates: _____

Have you experienced any of the following?

- ☐ **Anxiety**
- ☐ **Depression**
- ☐ **Insomnia**
- ☐ **ADD/ADHD**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Bipolar Disorder**
- ☐ **Schizophrenia**
- ☐ **Cancer**
- ☐ **Eating Disorder**
- ☐ **Neuropathy**
- ☐ **Chronic Pain**
- ☐ **Kidney Disease**
- ☐ **Migraines/Headaches**
- ☐ **Glaucoma**
- ☐ **Muscle Spasms**
- ☐ **Restless Leg Syndrome**
- ☐ **PTSD**
- ☐ **Spinal Problems**
- ☐ **Intestinal Problems**
- ☐ **Nausea/Lack of Appetite**
- ☐ **COPD**
- ☐ **Fibromyalgia**
- ☐ **Seizures or Epilepsy**
- ☐ **Diabetes**
- ☐ **Bladder Issues**
- ☐ **Reproductive Issues**
- ☐ **Menopause**
- ☐ **Substance Abuse**
- ☐ **Other: _____**

*****NOTE*** If a recommendation is provided by our physician, please be prepared to CREATE A PASSWORD for your patient account with the Oklahoma Medical Marijuana Authority. ONLY you will know this password. Our staff will have no access to it. _____ (patient initials)**

Alternative Medical
clinic of tulsa

Patient Consent & Acknowledgement

I hereby give my consent for Alternative Medical Clinic and their team of licensed physicians to evaluate my current/past medical history to determine if medical cannabis should be recommended. This patient evaluation may occur in person with one of our physicians or via telemedicine as permitted by the State of Oklahoma telemedicine statute.

My signature below is to attest that the information I have provided is true and accurate to the best of my knowledge. I also attest that I have provided all pertinent medications and conditions/diagnoses to the physician and his team.

I understand that the physician and his team have the right to refuse service at any time and that recommendation for medical cannabis use is based on medical evaluation. If you do not qualify, you will not be provided a recommendation during the visit.

I understand that this visit is not for treatment and that questions about my treatment plan are best reserved for my primary care/treating physician for continuity of care.

My signature below also serves to attest I have been offered a copy of the HIPAA Privacy Rules and have either obtained a copy or have opted to "Go Green" by reading it in the office during my visit.

I understand that medical cannabis comes in multiple forms for administration. It is recommended you consult with a licensed dispensary once you receive your approval and patient ID from the Oklahoma Medical Marijuana Authority (OMMA).

I understand approval for my patient ID is subject to rules and guidelines set forth by the OMMA.
I will not hold Alternative Medical Clinic of Tulsa, the physicians or staff liable for denials at the OMMA level.

Signature of Patient (or Legal Guardian):_____

Printed name of Patient or (Legal Guardian):_____

Date: _____

Relationship to Patient (if Legal Guardian): _____