Medicinal Cannabis Intake Form

Cannaisseur Brands
THERAPY Designed by Nature®

www.CannaisseurBrands.com

Fax or Email to:
310-507-0246 or
info@CannaisseurBrands.com

Date: _____

Tolerence to Medications (Circle One)

Low **Med** **High**

Physicians Name: _____ Tel. # _____

First Name: _____ Last: _____ Age: ____ Ht: _____ Wt: ____

Mailing Address: _____ Unit: _____

City: _____ State: _____ Zip: _____

Telephone: _____ D.O.B. _____

Email: _____ Gender: Male ☐ Female ☐

Diagnosis: _____

Date: _____ Stage: _____

Care Giver: _____ Relationship: _____

Telephone: _____ Email: _____

Please list medications dosage, frequency (daily), condition and other comments about usage below

Med/Sup	Dose	Freq	How long taking this product	Does it work/Side Effects

You seek medicinal cannabis to help: **(Check all that apply)**

Manage treatment side effects ☐
Reduce Synthetic Meds ☐
Anxiety ☐
Pain Relief ☐
Increase Energy Level ☐
Seizures/Spasms/Neuropathy ☐
Increase (Restful) Sleep ☐
Increase Appetite ☐

Other: Please Explain

Your experience with cannabis?

None to very little ☐
Some but not a lot ☐
Very experienced ☐

Additional Comments:

MMJ ID

State _____ # _____

8/21/2017

_____
Signature of Customer or Guardian
(Must be 21 or older)

"Everyone deserves the medicine they need"