Medicinal Cannabis Intake Information

www.CannaCauses.org

Date: _____

Physicians Name: _____ Tel. # _____

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

Mailing Address: _____ Unit: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Gender Male ☐ Female ☐

Email: _____

Diagnosis: _____ **Date** _____ **Tolerance to current medications** Low Med High

Stage: _____ **Is there a family history:** Yes or No

Care Giver: _____ Relationship: _____

Telephone: _____ Email: _____

Please rate the following **: On a scale of 1 to 10, 10 being the worst how would you rate on AVERAGE the following? Note: please rate both before and after taking you're the current medication**

Condition	Before	After	Medication	How Long	List any side effects
EXAMPLE	9	4	Oxycodon	8 yrs	Dizzy tired feeling, nausia
Anxiety					
Pain					
Neruopthy					
Spasticity					
Sleep					
Chemotherapy					
Radiation					
Please list any OTHER conditions and medications below add additional sheets as needed.					

MMJ ID

State _____ # _____

_____

Client or Guardian Signature

(Must be at least 21)

Apr-2018

Return this form by: Fax: 310-507-0246 OR Email: info@CannaisseurBrands.com

For more information or questions please call (424) 253-2208 ext. 420 **Please leave a detailed message**

"Everyone deserves the medicine they need"

CannaCauses Foundation (Cont.)

For Office Use Only

Cannabis Experience:

None to very little ☐ Some but not a lot ☐ Very Experenced ☐ Currently using ☐

Products Used: Smoke Edibles Tincture

Notes:

Recommendations

Tincture/Flavor	Ratio	Dosing	Other Suppliment(s)	By	Date

Notes: