releaf ALTERNATIVE MEDICINE

Phone: 856-343-4028
Email: info@releafaltmed.com
Website: ReleafAltMed.com
Fax: 856-316-7743

PATIENT INTAKE QUESTIONNAIRE

Name Date of birth

Street City State Zip

Cell Email Last 4 of SS#

Age Occupation Federal/State Employee? **Yes** **No**

State of Residency: **New Jersey** **Pennsylvania**

What is your diagnosis for the Medical Marijuana Program?

Chronic Pain
Anxiety
PTSD
Crohn's/Colitis/IBS
Migraines
Seizures/Epilepsy
Multiple Sclerosis
Cancer
HIV/AIDS
Muscle
Spasm
Tourette's ALS
Muscular
Dystrophy Terminal
Illness Glaucoma
Opioid Use Disorder

Do you have a primary care physician or specialist for your qualifying condition?

Yes **No**

If yes, what is the name of your primary care physician or specialist?

Physician Address Telephone Fax

Have you been evaluated for medical marijuana by any other physician in the past?

Yes **No**

If yes, please give name of doctor and condition for which cannabis was approved.

Have you had any of the following procedures:

Cancer Surgery
Spine Surgery
Surgery for Bowel Disease
Nerve Blocks (Ablation)
Spinal Cord Stimulator
Trigger Point Injections
Botox
Epidural

If you have PTSD: What trauma have you experienced, and what symptoms do you have?

Assault
Accident
War
Witness of Death
Sleep disturbance
Avoiding Situations
Detachment from others
Hypervigalence
Guilt/Worthlessness

If you have ANXIETY: Do you have any of the following?

Nervousness
Worry too much
Can't stop worrying
Irritability
Restlessness
Trouble Relaxing
Feeling Afraid

In a week, how often do you have these symptoms? Several Days Half Days Nearly Everyday

Please indicate if you have had any following medical problems:

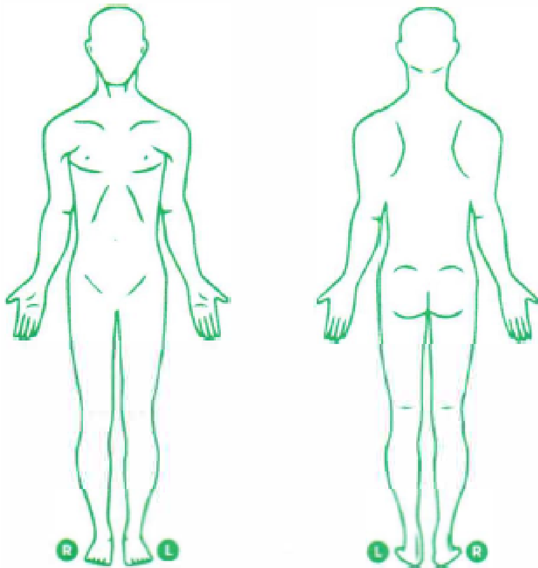
Liver Disease
Kidney Disease
Asthma
COPD
Heart Disease
Hypertension
Stroke
Schizophrenia

Do you have any of the following symptoms?

Weight Loss Fatigue Poor Appetite Nausea/Vomiting Insomnia

HOW IS PAIN AFFECTING YOU?

If you experience pain, please use the picture below to indicate where:



Rate your pain from 1-10

Without medication

With medication

Do you currently use marijuana?

Yes **No**

If yes, does is help with your symptoms above?

Yes **No**

Do you currently use tobacco?

Yes **No**

ARE YOU TAKING OR HAVE YOU TRIED ANY OF THE FOLLOWING MEDICATIONS:

Ativan	Paxil	Dilaudid	NSAID	Lamictal	Zanaflex
Klonopin	Lexapro	Oxycodone	Steroid	Keppra	Flexeril
Xanax	Seroquel	Vicodin	Biologic	Tegretol	Lyrica
Valium	Cymbalta	Fentanyl	Triptan	Trileptal	Neurontin
Elavil	Ambien	Methadone	Topamax	Dilantin	Soma
Zoloft	Morphine	Suboxone	Depakote	Baclofen	Skelaxin

Female Patients:

Are you pregnant? **Yes** **No** Are you planning a pregnancy/breastfeeding? **Yes** **No**

Opioid Patients:

Please list dose of opioid and number of pills per day

Prior Legal Issues:

Are you currently on parole/probation? **Yes** **No**

Have you ever been convicted OR are currently involved in court proceedings for the illegal use, possession or sale of marijuana or any other controlled substance? **Yes** **No**

If yes, provide detail

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT

Patient Signature: **Date:**

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INFORMED CONSENT AND PATIENT AGREEMENT, RELEASE ALL CLAIMS LIABILITY

I understand that the Releaf medical providers are addressing specific aspects of my medical care, and unless otherwise stated, are in no way establishing themselves as primary care provider. The Releaf physician or the physician assistant working under the supervision of a licensed physician is only evaluating, and if appropriate, confirming the therapeutic indication for the use of medical marijuana.

I have discussed the risks and benefits of using medical marijuana with the Releaf physician, medical provider or staff.

- Marijuana has sedative properties that may affect coordination and cognition. I have been specifically counseled not to drive a car, operate heavy machinery, or engage in any potentially hazardous activity while using medical marijuana. I may develop a dependency on marijuana through repeated use.
- Marijuana may cause other side effects, including dry mouth, nausea, headache, visual disturbances, increased heart rate, muscle relaxation, decreased coordination, lung irritation, weight loss or gain, altered body temperature, anxiety, paranoia, confusion, sedation, altered libido, altered perceptions, reduced testicular size and testosterone, menstrual abnormalities, fertility, and fetal exposure in pregnancy and breast feeding.
- Medicinal marijuana provides benefits in treating or alleviating pain or other symptoms associated with certain debilitating medical conditions; however, there exists a lack of scientific consensus concerning, but not limited to, the following areas: unknown risks, dosages, frequency of dosages, delivery routes and methods, the most suitable strains for the treatment of specific conditions, and which cannabinoid compounds affect which areas of the body.

I understand and agree as follows:

- I will notify Releaf if I experience any adverse side effects from the use of medical marijuana.
- My continued use of medical marijuana will be contingent on my achieving treatment objectives and the absence of untoward side effects of physical and psychological problems associated with marijuana use.
- If I use an opioid for pain I will inform my opioid prescribing provider that I am using medical marijuana.
- Reclaim Ability Patients: Patients on medical marijuana and opioid will work with their provider to reduce overall medication associated risks. Attempts will be made to wean or maintain opioid dose < 90 MME/day with the goal of < 50 MME within 6-12 months. MMP patient must be re-certified in person every 3 months. Coinciding with 3 month re-enrollment opioid use will be evaluated. Dose escalation of opioid medications while on medical marijuana should be considered failure of the medical marijuana program in controlling pain. This does not apply to patients with cancer pain, anxiety or movement disorder.
- Risk Mitigation: Patients on the medical marijuana programs may be subject to random urine drug screens and purchase history will be reviewed every 3 months to ensure compliance with NJ MMP.

I further understand that my failure to comply with the agreements and acknowledgments I have made in this document will be grounds for retraction of any authorization for me to continue to use medical marijuana.

My heirs, assigns, or anyone acting on my behalf, hold the Releaf physician, physician assistant, nurse practitioner, and staff, free of and harmless from any responsibility and liability resulting from my use of cannabis.

Patient Signature: Date:

Witness: Date:

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

RELEASE FROM:

Facility:

Address:

City, State, Zip:

Telephone:

Fax:

RELEASE TO:

Dr. Matthew Lesneski
Releaf Alternative Medicine
Phone: (856) 343-4028
Fax: (856) 316-7743
Email: info@releafaltmed.com

Patient Name: **Date of Birth:**

Purpose for release: Records Supporting Diagnosis Communication

Information to be released: Last Office Visit Note Imaging and Diagnostic Studies

I HAVE REVIEWED AND UNDERSTAND THIS AUTHORIZATION. I ALSO UNDERSTAND THAT THE INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND NO LONGER BE PROTECTED UNDER FEDERAL LAW.

Patient Signature: **Date:**