



INITIAL PATIENT INTAKE FORM

CONTACT INFORMATION

Name of Patient (First and Last): _____ Date of Birth (MM/DD/YYYY): _____

Patient ID #: _____ Exp. Date: _____

Photo ID / Driver's License #: _____ Exp. Date: _____ Gender: M F

Address: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____ Cell Phone: () _____

Would you like to receive notifications, by email or text, about upcoming news and promotions from The Botanist? Yes No

Recommending Physician: _____ Phone Number: () _____

Are you registered as a Terminal, Indigent or Veteran patient? Yes No If Yes, please specify which: _____

How did you hear about us? _____

MY DIAGNOSIS (Please check all that apply below)

- Alzheimer's Disease
- Amyotrophic Lateral Sclerosis
- Crohn's Disease
- HIV/AIDS
- PTSD
- Parkinson's Disease
- Sickle Cell Anemia
- Tourette's Syndrome
- Cancer
- Chronic Pain
- Chronic Traumatic Encephalopathy
- Epilepsy or another seizure disorder
- Fibromyalgia
- Glaucoma
- Hepatitis C
- Inflammatory Bowel Disease
- Multiple Sclerosis
- Spinal Cord Disease/Injury
- Traumatic Brain Injury
- Ulcerative Colitis
- Other (Please list if applicable) _____

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT

Patient Name (first and last): _____ Date of Birth (MM/DD/YYYY): _____

I understand, that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy in regards to my protected health information (PHI). I have received, read, and understand the Notice of Privacy Practices.

The Botanist reserves the right to change the terms of its Notice of Privacy Practices. I understand The Botanist will provide a current Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Authorized Patient's Representative: _____ Relationship: _____

Signature: _____ Date: _____



ACKNOWLEDGMENT OF DISCLOSURE AND ASSUMPTION OF RISK AGREEMENT

ACKNOWLEDGMENT OF DISCLOSURE AND ASSUMPTION RISK AGREEMENT

This Acknowledgment of Disclosure and Assumption of Risk Agreement has been prepared to provide you with information regarding the risks and side effects of using medical marijuana. It is important that you read this information carefully and completely. Please discuss any questions you may have with the dispensary pharmacist or your certifying physician. Once you have read and understand the attached information, and have had any questions addressed to your satisfaction, please sign and date the Acknowledgment of Disclosure and Assumption Risk Agreement.

Do not sign this Agreement and do not use medical marijuana if you have questions about or do not understand the information you have received or are not willing to assume all the risks that may be associated with medical marijuana use or possession.

RISKS AND SIDE EFFECTS OF MEDICAL MARIJUANA USE

Possession or use of this product is unlawful outside of the State of Ohio and prohibited by federal law. Medical marijuana may have intoxicating effects and has not been analyzed or approved by the United States Food and Drug Administration (“FDA”) and was produced without FDA oversight for health, safety, or efficacy. The efficacy and potency of medical marijuana may vary widely depending on the medical marijuana strain and ingestion method. When products infused with medical marijuana or active compounds of medical marijuana are eaten or swallowed, the intoxicating effects of this drug may be delayed by two or three hours or more (sublingual: one hour delay).

There is limited information on the side effects of using medical marijuana, and there may be associated health risks. Side effects of medical marijuana can include, but are not limited to: memory loss, irregular / increased heartbeat, low blood pressure, headache / nausea / vomiting, anxiety / nervousness, sexual impotence, agitation, sedation / slower reaction time, dry mouth, numbness, confusion, inability to concentrate, hunger / loss of appetite, dizziness, impairment of motor skills, cough / bronchitis, shortness of breath, dependency, poor physical condition, depression, impaired vision, feelings of euphoria, laryngitis / bronchitis, general apathy, drowsiness / fatigue, abnormal sleep, paranoia / psychotic symptoms and/or suppression of immune system.

Symptoms of medical marijuana overdose include, but are not limited to, nausea, vomiting, and disturbances to heart rhythm. The scientific basis for the medical use of medical marijuana has not been established. There is little known information regarding how medical marijuana may or may not react with other pharmaceutical or herbal medications. Some patients can become dependent on medical marijuana. This means they experience withdrawal symptoms when they stop using medical marijuana. Signs of withdrawal symptoms can include feelings of depression, sadness or irritability, restlessness or mild agitation, insomnia, sleep disturbance, unusual tiredness, trouble concentrating, and loss of appetite. All users can develop a tolerance to medical marijuana. This means higher and higher doses are required to achieve the same symptom relief. The possibility exists that medical marijuana may exacerbate schizophrenia, cardiac issues, psychosis or bipolar disorder in persons predisposed to those disorders. Woman should not consume medical marijuana products while planning to become pregnant, during pregnancy, or while breast feeding, except on the advice of the certifying health practitioner, and in the case of breast feeding mothers, on the advice of the infant’s pediatrician. Keep out of the reach of children and pets. Using medical marijuana while under the influence of alcohol is not recommended. The use of medical marijuana may affect coordination, cognition, and judgement. While under the influence of medical marijuana, do not drive, operate machinery, or engage in potentially hazardous activities. Please note that medical marijuana will degrade over time. Transporting medical marijuana across state lines is prohibited.

I certify that I have read the above Acknowledgment Disclosure and Assumption of Risk Agreement and I fully understand any potential risks and side effects related to the use of medical marijuana. In using medical marijuana for medicinal use, I fully accept responsibility and assume any risks and side effects associated with its use. I further hold harmless and release The Botanist of any liability related to any risks.

Date:

Patient Name (first and last):

Patient Signature:



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ADDITIONAL PATIENT INFORMATION (OPTIONAL)

Name of Patient (full legal name):

Emergency Contact:

Phone Number: ()

Are you pregnant or planning on becoming pregnant?

Yes No N/A

Have you ever suffered from psychosis?

Yes No

Have you ever had a cardiac episode?

Yes No

NEGATIVE SYMPTOMS THAT I AM CURRENTLY EXPERIENCING *(Please check all that apply below)*

- Abdominal Pain / Cramps Anxiety Depression Difficulty Falling Asleep
- Difficulty Remaining Asleep General Insomnia General Pain Hyperactive Bowels
- Migraine Muscle Pain Nausea Nerve Pain
- Ocular Pressure Poor Appetite Seizures
- Withdrawal: Opioids / Alcohol or Substance Abuse Other *(Please list if applicable)*

Other / Additional Health Conditions:

Frequency of Symptoms:

Current Medication and Dosage:

Alternative Medication / Vitamins / Supplements:

Allergies:

Do you smoke tobacco?

Yes No

Do you consume alcohol?

Yes No

How much?

How much?



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CANNABIS USE

I have used cannabis (marijuana) prior to this visit

Yes *No* *N/A*

Frequency of use *(please describe if you have answered 'Yes' above):*

Tolerance: 1 2 3 4 5

Negative effects experienced using cannabis *(please describe, if applicable):*

Positive effects experienced using cannabis *(please describe, if applicable):*

Positive outcomes I hope to achieve using medical cannabis: