Intessa
PAIN RELIEF SPA

NAME: _____

Please note: The doctor relies on your honesty to accurately assess your condition. Any breach of this trust has a negative effect on the Patient – Physician relationship.

What is the main medical condition you feel qualifies you for the Medical Marijuana Program? **Doctor's Use Only**

If chronic pain, please identify the part of your body affected. ☐

Approximately when did this condition first occur and under what circumstances? ☐

Describe the frequency and intensity of your pain, nausea or muscle spasms. ☐

Do you want to avoid prescription narcotics? ☐

What surgeries have you ever had? Include oral surgery, tonsillectomy, etc.:

Did/Do either of your parents have heart disease or diabetes? YES NO (please circle one)

Do you use tobacco? YES NO

Are you an Alcoholic? YES NO

Are What DAILY medications do you take?

Are you allergic to any medications? YES NO If yes:

Are you aware of any marijuana related legal action pending against you? YES NO

Hobbies/Activities: ☐

PLEASE NOTE: ANXIETY, DEPRESSION, INSOMNIA, ADD, ADHD AND BI-POLAR DISORDER ARE <u>NOT</u> QUALIFYING CONDITIONS.

SIGNATURE _____
DATE_____