Integrative Practitioners Medical Marijuana Program Health Assessment
(All responses are confidential)
Items with * require an answer

Please print and bring the completed form to your first appointment – thank you

Name ____

Address ____

City/Town/Zip ____

Email ____

Phone ____

DOB ___/____/_____

Can we contact you at this phone number?   Y   N

Can we leave a voice mail ?   Y   N

Can we email you?   Y   N

What is your primary language? ________________________

Are you working?

__F/T   __P/T   __Student   __Retired   __Disabled   __Other

Are you pregnant or planning to become pregnant?   Y   N

Are you breastfeeding?   Y   N

Do you have children or grandchildren under 18 at home?   Y   N

How did you hear about our Medical Marijuana Program?

__ Our Website   __NYS Medical Marijuana Website   ___ Provider   ___ Family/Friend

Who referred you to our practice? ______________________________

What other Health Care Providers do you see?

__ Pain Specialist	__ Infectious Disease	__ Cardiology	__ OB/Gyn
__ Neurology	__ Rheumatology	__ Psychiatrist/Psychologist/ Therapist	__Primary Care
__ Orthopedics	__ Pulmonology	__ Hematology/Oncology	__ Other

What results do you hope to see from using Medical Marijuana?

__ Symptom Relief (decreased tremors, spactisity, etc)

__ Better appetite

__ Pain relief

__ Improved mood

__ Improved sleep

Other ___________________________________

Current health issues – please check all that apply

__ Heart Attack	__ Stroke	__ Other Cardiac	__ Irreg Heart Beat	__ High Blood Pressure
__ Chest Pain	__ Palpitations	__ Swelling	__ Asthma	__ COPD
__ Tuberculosis	__ Sleep Apnea	__ Use CPAP	__ IBS	__ IBD
__ Crohns	__ GERD	__ Ulcers	__ Ulcerative Colitis	__ Liver Problems
__Osteoarthritis	__ Rheumatoid Arthritis	__ Other Bone/ Joint	__ Chronic Fatigue Syn.	__ Lyme
__ Fibromyalgia	__ AutoImmune	__ SLE/Lupus	__ MS	__ Parkinson's
__ Huntington's	__ Spacticity	__ Epilepsy	__ ALS	__ Spinal Cord Injury
__ Neuropathy	__ HIV/AIDS	__ Type I Diabetes	__ Type II Diabetes	__Hypoglycemia
__ Cancer	__Depression/ Anxiety	__ Recent Surgery	__ Chronic Pain	__ Substance Abuse/Addiction
__ BiPolar	__ Autism	__ Personality Disorder	__ Seizures	__ Panic Attacks
__ Schizophrenia	__ PTSD	__ Memory Loss	__ Dizzy Spells	__ Hallucinations
__ Hepatitis C	__ Muscle Spasms			

Do you use tobacco? Y N What form (smoked, pipe, chew) _______

How long have you been using? ______

Do you use alcohol? Y N What kind? __________ How many drinks per week? _____

Do you currently use marijuana? Y N

What form? ____________ How often ______

Do you use other recreational drugs/IV Drugs? Y N What kind? ______

Do you feel you get enough sleep Y N

Do you have trouble falling asleep or staying asleep? Y N

Do you use sleep aids? Y N What types? ____________

Do you have allergies or bad reactions to medications or supplements?

Please list all ____

Current medications and supplements

Medication	Dose/How Often	Reason

Use the back of the page if needed

Do you have chronic pain? Y N

If yes, please describe where, when, type (numbness, sharp, burning, aches) and what treatment or medications you use to help the pain:

What other treatments do you use?

__ Massage	__ Chiropractic	__ Reiki	__Acupuncture/ Pressure
__ Cranial-Sacral	__Physical Therapy	__ Light Therapy	__ Occupational Therapy
__ Heat/Ice	__Meditation	__ Biofeedback	__ Yoga
__Infrared	__ Spiritual Practice	__ Other – what?	

What else would you like us to know about you?
Thanks for taking the time to complete this assessment!

Remember to bring a copy to your first appointment OR you can fax it to us at 315.221.9736 or 315.825.4303. We would rather you did NOT email us as regular email does not ensure the confidentiality of the document.