PRIME WELLNESS
OF CONNECTICUT

NEW PATIENT INTAKE FORM

Name: _____ _____
Last Name First Name

Date of Birth: MM / DD / YYYY **Gender:** ☐ Male ☐ Female

Address: _____

Town: _____ **State:** _____ **Zip Code:** _____

*** Preferred method of contact. For internal promotional use only.*

Home Phone: _____ ☐ Morning ☐ Afternoon ☐ Evening

Cell Phone: _____ ☐ Morning ☐ Afternoon ☐ Evening

Carrier (e.g. Verizon, AT&T): _____ **Email** _____

Primary Care Physician: _____
Doctor who you normally see on a regular basis

MMJ Registering Physician: _____
Doctor who qualified you for the Medical Marijuana Program

Registered Caregiver (if applicable): _____ **Phone Number:** _____
A Registered Caregiver is a person chosen by the patient to act as their agent in obtaining their medication at the dispensary. If you feel that you need a caregiver, please contact your qualifying physician.

Are you a veteran? (Please check one) ☐ Yes ☐ No *IF YES, PLEASE PROVIDE DOCUMENTATION

Are you pregnant, planning to become pregnant or breastfeeding?
☐ Yes ☐ No ☐ N/A

How did you hear about us?

☐ Website ☐ Department of Consumer Protection ☐ News Article

☐ Leafly ☐ Referred ☐ Search Engine

My State Approved Diagnosis: (Please check all that apply)

- ☐ Cancer
- ☐ Cachexia
- ☐ Crohn's Disease
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Cerebral Palsy
- ☐ Cystic Fibrosis
- ☐ Complex Regional Pain Syndrome
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Muscular Dystrophy
- ☐ Multiple Sclerosis
- ☐ Neuropathic Facial Pain
- ☐ Parkinson's Disease
- ☐ Severe Psoriasis & Psoriatic Arthritis
- ☐ **P**ost-**T**raumatic **S**tress **D**isorder
- ☐ Sickle Cell Disease
- ☐ Osteogenesis Imperfecta
- ☐ Post Herpetic Neuralgia
- ☐ Intractable Headache Syndromes
- ☐ Hydrocephalus with Intractable Headache
- ☐ Severe Rheumatoid Arthritis
- ☐ Uncontrolled Intractable Seizure Disorder
- ☐ Wasting Syndrome
- ☐ Terminal Illness Requiring End-Of-Life Care
- ☐ Ulcerative Colitis
- ☐ Post Laminectomy Syndrome with Chronic Radiculopathy
- ☐ Spasticity or Neuropathic Pain Associated with Fibromyalgia
- ☐ Positive status for Human Immunodeficiency Virus (HIV) Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Irreversible Spinal Cord Injury with Objective Neurological Indication of Spasticity
- ☐ Damage to the Nervous Tissue of the Spinal Cord with Objective Neurological Indication of Intractable Spasticity
- ☐ Chronic Neuropathic Pain Associated with Degenerative Spinal Disorders
- ☐ Interstitial Cystitis
- ☐ MALS Syndrome (Median Arcuate Ligament Syndrome)
- ☐ Vulvodynia and Vulvar Burning
- ☐ Intractable Neuropathic Pain that Is Unresponsive to Standard Medical Treatments
- ☐ Tourette Syndrome

Please Note: Additional conditions will be added over time, please check the department of Consumer Protection website for changes to the list at www.ct.gov/dcp

Negative symptoms that I am currently experiencing: (Please check all that apply)

- ☐ Anxiety
- ☐ Depression
- ☐ Abdominal Pain/Cramping
- ☐ Difficulty Falling Asleep
- ☐ Difficulty Remaining Asleep
- ☐ Fatigue
- ☐ Hyperactive Bowels
- ☐ Migraine
- ☐ Nausea
- ☐ Ocular Pressure
- ☐ Pain
- ☐ Poor Appetite
- ☐ Seizures
- ☐ Tremors
- ☐ Inflammation
- ☐ Other: _____

Frequency of Symptoms: _____

Additional Health Conditions: _____

_____

Current Medication	Dosage

☐ I am not currently taking any medications

Allergies:

_____

_____

_____

Alternate Medicine	Vitamins

Do you smoke tobacco? (Please check one): ☐ Yes ☐ No

Do you drink alcohol? (Please check one): ☐ Yes ☐ No

Have you used marijuana prior to this visit? ☐ Yes ☐ No ☐ N/A

If yes, are you currently using and how often? _____

_____

Please Describe, If Applicable

Negative effects experienced using marijuana (if applicable):

_____

Positive effects experienced using marijuana (if applicable):

_____

Positive outcomes I hope to achieve using medical marijuana:

_____

My preferred method of Medical Marijuana consumption: (Please check what applies below, if known)

☐ Smoking ☐ Vaporizing ☐ Consumables (Edibles) ☐ I Am Uncertain

☐ Oils ☐ Tinctures ☐ Concentrates