



Alternative MEDICINE CONSULTANTS

CALL 877.420.CURE (2873)

www.alternativemedicineconsultants.com

Circle Location:

Anaheim Location
1120 West La Palma #2
Anaheim, CA 92801

Chino Location
5857 Pine Ave.
Chino Hills, CA 91709

San Bernadino Location
1881 Commercenter East, Suite 122
San Bernardino, CA 92408

Victorville Location
14318 California St., Suite 101
Victorville, CA 92392

PATIENT INTAKE FORM

Name _____ Date _____
(First Middle Last)

Height _____ Weight _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Phone _____ (circle: home / work / cell) E-mail _____

What is your occupation? _____

Do you have medical insurance? Yes / No If yes, what type/company? _____

Do you have a primary care provider? Yes / No If yes, please identify:

Name _____ Address _____ Phone _____

Specialist/Consultant Name and Location 1) _____

Name and Location 2) _____

Name and Location 3) _____

What is/are the main medical problem(s) for which you seek a medical marijuana evaluation today?

When was the last time you saw your doctor/specialist about these complaints? _____

Which treatment modalities have you tried in treating your problems? (Please circle all that apply.)

medications herbs surgery therapeutic injections physical therapy osteopathic care
chiropractic care acupuncture homeopathy counseling other _____

Have you ever been hospitalized? Yes / No If yes, give details and dates: _____

Have you ever had any surgeries? Yes / No If yes, give details and dates: _____

Patient Signature _____ Doctor's initials _____



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PATIENT INTAKE FORM

Are you taking any medications or herbs? Yes / No If yes, please list: _____

Do you have any allergies to any medications? Yes / No If yes, please identify: _____

Do you smoke tobacco? Yes / No If yes, how much? _____

Do you drink alcohol? Yes / No If yes, how much? _____

Do you currently use cannabis (marijuana) for your medical condition? Yes / No / Currently Use
If yes, how many times (circle one): a day / week / month? _____

If yes, what is/are your preferred method(s) or cannabis use?

Inhaled: vapor smoke (joint / pipe/ bong)

Ingested: tea capsules butter/oil tincture baked goods other _____

Suppository: rectal vaginal

Topical: tincture cream/ointment poultice parabath DMSO spray

How does cannabis compare with the other medications that you take for your medical problems?

Have you experienced any of the following symptoms? (*Please check all that apply and initial at end of list.*)

- Blood in stools
- Chest pain
- Constipation
- Cough
- Coughing blood
- Depression
- Diarrhea
- Difficulty swallowing
- Easy bleeding or bruising
- Eye problems
- Fever
- Hearing problems
- Heart palpitations
- Heartburn
- Loss of appetite
- Nervousness
- Urination Pain
- Rectal pain
- Seizures
- Skin rashes
- Stomach pain
- Swollen ankles
- Toothache
- Vomiting *Initials* _____

Have you ever been exposed to asbestos, chemicals, poisons or radiation (besides X-rays)? Yes / No
If yes, please explain: _____

Are there health/medical problems that occur frequently in your family? Yes / No
If yes, please explain: _____

Have you brought with you today medical records or other documents or items that support the
medical condition(s) identified above? Yes / No If no, why not and when will these be obtained?

Patient Signature _____ Doctor's initials _____