PRIME WELLNESS
OF CONNECTICUT

INITIAL 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 Authorized 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 what applies below)

☐ Amyotrophic Lateral Sclerosis (ALS) ☐ Cachexia ☐ Cancer

☐ Complex Regional Pain Syndrome ☐ Crohn's Disease

☐ Damage to the Nervous Tissue of the Spinal Cord with Objective Neurological Indication of Intractable Spasticity

☐ Epilepsy ☐ Glaucoma ☐ Multiple Sclerosis

☐ Parkinson's Disease ☐ Positive status for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)

☐ Cerebral Palsy ☐ Cystic Fibrosis

☐ Irreversible Spinal Cord Injury with Objective Neurological Indication of Spasticity

☐ Terminal Illness Requiring End-of-Life Care ☐ Uncontrolled intractable Seizure Disorders

☐ Post Laminectomy Syndrome w/ Chronic Radiculopathy

☐ Post-Traumatic Stress Disorder (PTSD) ☐ Severe Psoriasis & Psoriatic Arthritis

☐ Ulcerative Colitis ☐ Wasting Syndrome ☐ Sickle Cell Disease

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 what applies below)

☐ Abdominal Pain / Cramping ☐ Anxiety ☐ Depression

☐ 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

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 your 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)

☐ Oils ☐ Tinctures ☐ Concentrates

☐ I am uncertain