

Evaluation Type: ☐ New Patient ☐ Renewing Patient ☐ Extended Plant Count ☐ Emotional Support Animal		First Name:		Last Name:		Gender:		
Email Address:				Phone:		Date of Birth: (MM/DD/YYYY)		Age:
Street Address:				City:		State: CO		Zip Code:
Previous Cannabis Use: ☐ Use it daily ☐ Used it in the past ☐ Never used it				Social Security Number (Full SSN Required by State Law)				Are you a Veteran? ☐ Yes ☐ No

Referred by:

☐ Family/Friends: ☐ Online Search, Which site?: _____ ☐ Social Media, Which site?: _____ ☐ Dispensary, Which one?: _____

Legal Questions

Do you have any open cases with Child Protection Services? ☐ Yes ☐ No	Do you currently have any open legal cases? ☐ Yes ☐ No
Are you currently on probation or expect to be on probation? ☐ Yes ☐ No	Are you on probation for drug related charges? ☐ Yes ☐ No
Do you need a letter for probation or for the courts? ☐ Yes ☐ No	*Medical records and/or further documentation may be required for patients who are on or expecting to be on probation, have any open legal cases, or have any cases with CPS.

Medical Questions

Ethnicity: ☐ White/Caucasian ☐ Black/African American ☐ American indian/Native ☐ Asian ☐ South Asian ☐ Pacific Islander ☐ Hispanic ☐ Middle Eastern

Height:	Weight:	List ONE PRIMARY condition: ☐ Cancer ☐ Glaucoma ☐ HIV/AIDS ☐ Cachexia ☐ Seizures ☐ Severe Pain ☐ Severe Nausea ☐ Persistent Muscle Spasms ☐ PTSD ☐ Autism ☐ Acute Pain and/or Post OP Pain ☐ As an Alternative to Narcotics
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List all other SECONDARY condition(s):

Primary Care Provider Name: _____	Specialists Name / Speciality: _____	May we contact?:
Contact info: _____	Contact info: _____	☐ Primary Care Provider ☐ Specialist

Medications (Include MG/ML & Frequency):

Medication Allergies: _____ _____ _____	Therapies (Past and Current):		Past Surgical History: _____ _____ _____																																						
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Do you smoke tobacco? ☐ No ☐ Yes Per Day _____ Per Week _____ Per Month _____	Do you drink alcohol? ☐ No ☐ Yes Per Day _____ Per Week _____ Per Month _____	Do you use any illicit drugs? ☐ No ☐ Yes What substance(s): _____
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Do you struggle with substance abuse? ☐ No ☐ Yes What substance(s): _____	Are you currently in any of the following programs? ☐ Methadone/Suboxone Replacement Therapy ☐ Alcohol Withdrawal Management ☐ Addictions Related Mental Health Counseling
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Any history of psychosis? ☐ Yes ☐ No ☐ Family History	Any history of schizophrenia? ☐ Yes ☐ No ☐ Family History	Do you have any family history of cardiac conditions? ☐ Yes ☐ No
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Are you currently pregnant, breast feeding, or plan to be pregnant? ☐ Yes ☐ No	What forms of contraceptive(s) are you using? ☐ None ☐ Hysterectomy ☐ Vasectomy ☐ Condoms ☐ Birth Control ☐ Progesterone Implant ☐ Tubal Ligation ☐ IUD
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I attest the above information to be updated and true to the best of my knowledge.

I authorize Relaxed Clarity to contact me using the phone number and email address I provided. I understand authorization for a release of this information is required.

Patient's Signature:

Today's Date:

This survey asks for your views about your health. This information will help our clinic keep track of how you feel and how well you are able to do your usual activities. If you are unsure how to answer a questions, please give the best answer you can:

1. In general, how would you describe your overall health?

(Poor) (Fair) (Good) (Very Good) (Excellent)

2. On a typical day, does your health limit you in the following activities?

Moderate activities, such as moving a table, pushing a vacuum, bowling, or things such as golf?

(None - Does not limit) (Yes, limit a little) (Yes, limit a lot)

Climbing several flights of stairs.

(None - Does not limit) (Yes, limit a little) (Yes, limit a lot)

3. Over the past 4 weeks, have you had any of the following problems with your work or other activities as a result of your physical health?

Accomplished less than you would like.

(No) (Yes)

I have been limited in certain kinds of work/activities.

(No) (Yes)

4. Over the past 4 weeks, have you had any of the following problems with your work or other activities as a result of any emotional problems i.e. Anxiety or depression?

Accomplished less than you would like.

(No) (Yes)

Did work or activities less carefully than usual

(No) (Yes)

5. Over the past 4 weeks, how much did pain interfere with any work or any activities?

(Not at all) (A Little Bit) (Moderately) (Quite a bit) (Extremely)

6. Considering the past 4 weeks, please give the answer that comes closest to the way you have been feeling:
Calm and peaceful.

(None) (A little) (Sometimes) (Most times) (All of the time)

A lot of energy.

(None) (A little) (Sometimes) (Most times) (All of the time)

Downhearted and blue.

(None) (A little) (Sometimes) (Most times) (All of the time)

7. Over the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities i.e. visiting friends/family etc.

(None) (A little) (Sometimes) (Most times) (All of the time)

Consent for Treatment

This visit is limited to an evaluation of your health/medical condition for the purposes of a Medical Marijuana Certification. If you desire additional medical treatment, a separate appointment and payment of the office fees will be required. This is not a dispensary of Medical Marijuana, and you are not being referred to any specific dispensary.

I have read and understand this consent to an evaluation by a professional evaluation centers physician, and payment of office fees agreed. This consent may be revoked at any time.

I attest the above information to be updated and true to the best of my knowledge.

I authorize Relaxed Clarity to contact me using the phone number and email address I provided. I understand authorization for a release of this information is required.

Patient's Signature:

Today's Date:

Relaxed Clarity

Print Name:

DOB:

Do you have cannabis experience? ☐ No

☐ Yes Average Dosage: _____ Gram/Day Mg/Day Ml/Day

Cannabinoid Profile Ratio (THC:CBD) _____ :

Past Usage:

☐ Daily ☐ Weekly ☐ Monthly ☐ Past Use

Time of day used:

☐ Morning ☐ Afternoon ☐ Evening ☐ Night

Form of administration:

☐ Topical ☐ Inhalation ☐ Oral ☐ Oromucosal

Which of the follow POSITIVE EFFECTS have you experienced?

- | | |
|--|--|
| ☐ Energetic | ☐ Euphoric |
| ☐ Improved Appetite | ☐ Improved Fatigue |
| ☐ Improved Mood | ☐ Improved Sleep |
| ☐ Improved Relations | ☐ Increase in Mobility |
| ☐ Increased Creativity | ☐ Increased Focus |
| ☐ Increased Motivation | ☐ Increased Productivity |
| ☐ Pain Reduction | ☐ Reduced Anxiety |
| ☐ Reduced Bowel Movements | ☐ Reduced Headache/Migraine |
| ☐ Reduced Nausea | ☐ Reduced Seizures |
| ☐ Reduced Stress | ☐ Reduced Vomiting |
| ☐ Relaxing | ☐ Uplifted |

NEGATIVE EFFECTS of cannabis have you experienced?

- ☐ Dizziness
- ☐ Drowsiness
- ☐ Dry Eyes
- ☐ Dry Mouth
- ☐ Fatigue
- ☐ Headache
- ☐ Increased Anxiety
- ☐ Increased Appetite
- ☐ Increased Heart Rate
- ☐ Memory Loss
- ☐ Paranoia
- ☐ Red Eyes

Know your medication and privacy practices

Medical cannabis is used in treating debilitating and disabling medical conditions, defined as limiting life activities.

Relaxed Clarity and MedEval practitioners and staff are addressing specific aspects of a patient's medical care. The practitioners and staff are in no way establishing themselves as the primary care provider.

Cannabis potency varies with the strain and the method of consumption. Determining the appropriate cannabis dosage may require a trial and error approach. Always start at the lowest dosage and increase it gradually. The use of cannabis affects coordination and cognition and impairs the ability to drive or engage in potentially hazardous activities. Wait at least six hours after cannabis use before operating any equipment.

Smoking cannabis may cause respiratory illness. Any ill effects experienced with the use of cannabis requires discontinuation of the drug and medical evaluation. Nausea, palpitations and numbness are symptoms of cannabis in excess. Chronic use of cannabis may lead to general apathy in a few patients, or to rare psychosis in those predisposed to the condition (usually in teenagers.) A vaporizer may substantially reduce many of the harmful toxins that are present in cannabis smoke. Oral cannabis preparations are less harmful, as are topical products.

Cannabis should not be used if you are pregnant, become pregnant, or if you are breastfeeding. If reproductive - age woman uses cannabis, and it not contracepting, she must discontinue cannabis use as soon as pregnancy is recognized.

Smoking cannabis in public or within 1000 feet of a school or daycare is illegal.

Some patients may experience symptoms when they stop using cannabis. This includes, but are not limited to, irritability, insomnia, loss of appetite, restlessness, trouble concentrating and fatigue.

Cannabis is not regulated by the Food and Drug Administration and may contain unknown quantities of active ingredients and impurities. Possession of cannabis is still currently illegal under Federal Law. Relaxed Clarity and MedEval practitioners and staff are neither prescribing nor dispensing cannabis. If approved, our certification is that a qualifying medical condition exists and that the potential benefits of medical cannabis appear to outweigh the risks.

I acknowledge, under federal guidelines of the HIPAA Privacy Notice, that I have been given the opportunity to thoroughly read and have had any questions answered about the notice of Privacy Practices at Relaxed Clarity, MedEval, Canna Care Docs, and MVC USA, Inc. I acknowledge receipt of the Notice of Privacy Rights with detailed information regarding how my personal health care information may be used and disclosed. I acknowledge that Relaxed Clarity, MedEval, Canna Care Docs, and MVC USA, Inc reserve the right to change the privacy notice and that a copy of the revised notice will be made available to me.

I acknowledge, without my written consent, my medical records will not be shared. Records kept on file are confidential. A HIPAA release form or PHI Form will be required to release records to any other individual.

Patient Signature:

Today's Date:

Brief Pain Intake (BPI)

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

No

2. Write the areas down where you feel pain and the area where it hurts most in the comment box.

[illegible]

3. Please rate your pain by selecting the one number that best describes your pain at its WORST in the past 24 hours.

[illegible]

4. Please rate your pain by selecting the one number that best describes your pain at its LEAST in the past 24 hours.

[illegible]

5. Please rate your pain by selecting the one number that best describes your pain on AVERAGE.

[illegible]

6. Please rate your pain by selecting the one number that best describes your pain RIGHT NOW.

[illegible]

7. What treatments or medications are you receiving for your pain?

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9. Please circle the one number that describes how, during the past 24 hours, PAIN HAS INTERFERED with your:

a) General Activity

[illegible]

b) Mood

[illegible]

c) Walking Ability

[illegible]

d) Normal Work (Includes both outside the home and housework)

[illegible]

e) Relations with other people

[illegible]

f) Sleep

[illegible]

g) Enjoyment of life

[illegible]

8. In the past 24 hours, how much RELIEF have pain treatments or medications provided; Please select one percentage.

[illegible]