PRIME
ALTERNATIVE TREATMENT CENTERS

INITIAL PATIENT INTAKE FORM

Name: _____ **Registry ID:** _____
(Please, print legibly)

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: _____

TCP Authorized Physician: _____
Doctor who qualified you for the Therapeutic Cannabis 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 inquire with a receptionist.

Are you a veteran? (Please check one) ☐ Yes ☐ No *IF YES, PLEASE PROVIDE DOCUMENTATION FOR A 10% DISCOUNT ON PURCHASES*

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

How did you hear about us?

☐ Website ☐ Department of Health and Human Services ☐ News Article

☐ Leafly ☐ Referred ☐ Search Engine

My State Approved Condition(s): (Please check what applies below)

☐ Acquired Immune Deficiency Syndrome

☐ Alzheimer's Disease

☐ Amyotrophic Lateral Sclerosis

☐ Cachexia

☐ Cancer

☐ Chemotherapy-Induced Anorexia

☐ Chronic Pancreatitis

☐ Crohn's Disease

☐ Ehlers-Danlos Syndrome

☐ Epilepsy

☐ Glaucoma

☐ Hepatitis C

☐ Lupus

☐ Moderate to Severe Chronic Pain

☐ Moderate to Severe Post-Traumatic Stress Disorder

☐ Multiple Sclerosis

☐ Muscular Dystrophy

☐ Parkinson's disease

☐ Positive Status for Human Immunodeficiency Virus

☐ Spinal Cord Injury or Disease

☐ Traumatic Brain Injury

☐ Ulcerative Colitis

☐ Wasting Syndrome

Please Note: Additional conditions will be added over time, please check the Department of Health and Human Services website for changes to the list at https://www.dhhs.nh.gov/oos/tcp/

Additional Health Conditions:

_____

_____

_____

Positive outcomes I hope to achieve using Therapeutic Cannabis:

_____

_____

Negative symptoms that I am currently experiencing: (Please check what applies below)

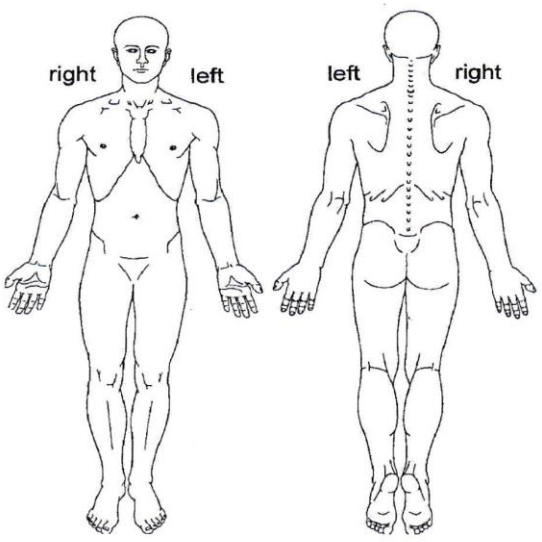
☐ Abdominal Pain / Cramping	☐ Anxiety	☐ Back Pain
☐ Chest Pains	☐ Depression	☐ Difficulty Falling / Staying Asleep
☐ Dizziness	☐ Elevated Ocular Pressure	☐ Fatigue
☐ Headaches	☐ Heartburn / Reflux	☐ Hyperactive Bowels
☐ Inflammation	☐ Irritability	☐ Memory Changes
☐ Migraine	☐ Muscle Cramps	☐ Muscle Spasms / Tremors
☐ Nausea	☐ Numbness / Tingling	☐ Pain
☐ Painful Muscles	☐ Painful / Swollen Joints	☐ Panic Attacks
☐ Paranoia	☐ Poor Appetite	☐ Seizures
☐ Shortness of Breath	☐ Sleep Apnea	☐ Trouble with Balance
☐ Vomiting	☐ Weakness	

☐ Other: _____

PAIN PATTERNS MAP →→→

On the figures provided to the right, please "illustrate" your areas of pain and/or numbness using the following key:

Moderate Pain = O O O O O
Severe Pain = X X X X X
Numbness = N N N N N
or tingling.



Current Medication(s)	Dosage

Allergies:

Alternative Medicine(s)	Vitamins

Do you take Medications for the following conditions? (Please circle one)

Blood Pressure **Immune Disorder** **Organ Transplant** **Hyperthyroidism**

Hypothyroidism **Diabetes Mellitus I** **Diabetes Mellitus II** **High Cholesterol**

Nerve Pain **Heart Condition**

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

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

Do you live alone? (Please check one): ☐ Yes ☐ No

Are you currently employed? (Please check one): ☐ Yes ☐ No

Is there a time of day that your symptoms seem to be worse?
(Please describe, If applicable)

_____

_____

_____

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

If yes, How Often are you Using Therapeutic Cannabis/Cannabis and How Has it Helped You? _____

_____

_____

Please describe, If applicable

Positive Effects Experienced using Therapeutic Cannabis (if applicable):

_____

_____

Negative Effects Experienced using Therapeutic Cannabis (if applicable):

_____

_____

<u>My Preferred Method of Therapeutic Cannabis Consumption:</u> (Please check what applies below)

☐ Inhalation (Smoking) ☐ Vaporizing ☐ Consumables (Edibles)
☐ Oils ☐ Tincture ☐ Concentrates
☐ I am uncertain ☐Other: _____

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient Name: _____ **Date of Birth:** _____

I understand, that under the Health Insurance Portability Act of 1996, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read, and understand the Notice of Privacy Practices.

Prime Alternative Treatment Centers reserves the right to change the terms of its Notice of Privacy Practices. I understand Prime Alternative Treatment Centers will provide a current Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Authorized Patient's Representative: _____

Relationship: _____

Signature: _____ Date: _____

---------- **FOR OFFICE USE ONLY** ----------

I was unable to obtain the patient / patient's representative's signature.

Employee's Name: _____ Date: _____

Reason: _____

Acknowledgement of Disclosure and Assumption of Risk Agreement

This Acknowledgement of Disclosure and Assumption of Risk Agreement has been prepared to provide you with information regarding the risks and side effects of using Therapeutic Cannabis. It is important that you read this information carefully and completely. Please discuss any questions you may have with the dispensary technician or your certifying physician. Once you have read and understand the attached information, and have had any questions addressed to your satisfaction, please sign and date the Acknowledgement of Disclosure and Assumption Risk Agreement.

Do not sign this Agreement and do not use Therapeutic Cannabis if you have questions about or do not understand the information you have received or are not willing to assume all the risks that may be associated with Therapeutic Cannabis use or possession.

Risks and Side Effects of Therapeutic Cannabis Use

Possession or use of this product is unlawful outside of the State of New Hampshire and prohibited by Federal law.

Therapeutic Cannabis may have intoxicating effects and has not been analyzed or approved by the United States Food and Drug Administration (“**FDA”)** and was produced without FDA oversight for health, safety, or efficacy. Therapeutic Cannabis may contain unknown quantities of active ingredients, impurities, or contaminants.

The efficacy and potency of therapeutic cannabis may vary widely depending on the Therapeutic Cannabis strain and ingestion method.

If Therapeutic Cannabis is smoked or vaporized: Smoking may be hazardous to your health. Therapeutic Cannabis smoke contains carcinogens and may lead to an increased risk of cancer, tachycardia, hypertension, heart attack, birth defects, brain damage, and lung disease.

If Therapeutic Cannabis is eaten or swallowed: When products infused with therapeutic cannabis or active compounds of therapeutic cannabis are eaten or swallowed, the intoxicating effects of this drug may be delayed by two or three hours or more.

There is limited information on the side effects of using Therapeutic Cannabis, and there may be associated health risks. Side effects of Therapeutic Cannabis can include, but are not limited to:

- Memory loss
- Anxiety/Nervousness
- Dry mouth
- Irregular/Increased heartbeat
- Sexual impotence
- Hunger/Loss of appetite
- Dizziness/Impairment of motor skills
- Cough/Bronchitis/Shortness of Breath
- Dependency
- Poor physical condition
- Depression

- Numbness
- Low blood pressure
- Agitation
- Confusion
- Headache/Nausea/Vomiting
- Sedation/slower reaction time/Inability to concentrate
- Impaired vision
- Feelings of euphoria
- Laryngitis/Bronchitis/General Apathy
- Drowsiness/Fatigue/Abnormal sleep
- Paranoia/Psychotic Symptoms
- Suppression of immune system

Symptoms of Therapeutic Cannabis overdose include, but are not limited to, nausea, vomiting, and disturbances to heart rhythm.

The scientific basis for the medical use of Therapeutic Cannabis has not been established. There is little known information regarding how Therapeutic Cannabis may or may not react with other pharmaceutical or herbal medications.

Some patients can become dependent on Therapeutic Cannabis. This means they experience withdrawal symptoms when they stop using Therapeutic Cannabis. Signs of withdrawal symptoms can include feelings of depression, sadness or irritability, restlessness or mild agitation, insomnia, sleep disturbance, unusual tiredness, trouble concentrating, and loss of appetite.

Some users can develop a tolerance to Therapeutic Cannabis. This means higher and higher doses are required to achieve the same symptom relief.

The possibility exists that Therapeutic Cannabis may exacerbate schizophrenia or bipolar disorder in persons predisposed to those disorders.

Woman should not consume Therapeutic Cannabis products while planning to become pregnant, during pregnancy, or while breast feeding, except on the advice of the certifying health practitioner, and in the case of breast feeding mothers, on the advice of the infant's pediatrician. Keep out of the reach of children and pets.

Using Therapeutic Cannabis while under the influence of alcohol is not recommended.

The use of Therapeutic Cannabis may affect coordination, cognition, and judgement. While under the influence of Therapeutic Cannabis, do not drive, operate machinery, or engage in potentially hazardous activities.

Please note that medical marijuana will degrade over time. *I certify that I have read the above Acknowledgment Disclosure and Assumption of Risk Agreement and I fully understand any potential risks and side effects related to the use of Therapeutic Cannabis. In using Therapeutic Cannabis for medicinal use, I fully accept responsibility and assume any risks and side effects associated with its use. I further hold harmless and release Prime Alternative Treatment Centers of any liability related to any risks.*

Patient Signature: _____ Date: _____

Patient Name: _____

Therapeutic Cannabis Program Patient Agreement

I agree that the following statements are true and accurate:

I am registered with and understand the requirements of the State of New Hampshire's Therapeutic Cannabis Program.

I agree to strictly comply with the regulations, terms and conditions of the State of New Hampshire's Therapeutic Cannabis Program including, but not limited to, ensuring that no Therapeutic Cannabis obtained by me shall be used for any other purpose than as directed by my certifying physician and such therapeutic cannabis is not resold, distributed, or otherwise possessed or used by any other person.

I have been advised of the possible risks and side effects associated with using Therapeutic Cannabis by my certifying physician and dispensing pharmacist and have decided to assume such risks.

If I start using Therapeutic Cannabis, I agree to tell my physician if I experience any one or more of the following:

- Start to feel sad or have crying spells
- Have changes in my normal sleep patterns
- Lose my appetite
- Become more irritable than usual
- Become unusually tired
- Withdraw from my family and friends
- Lose interest in my usual activities
- Any other side effects included in but not limited to the Acknowledgement of Disclosure of Risk Agreement

In the event that I experience a severe adverse reaction, I agree to immediately contact my physician. In the event that my physician is not available, I agree to call 911 for help.

I agree to tell my physician if I have ever had symptoms of schizophrenia, bipolar disorder, psychotic episodes or have attempted suicide. I also agree to tell my physician if I have ever been prescribed or taken medication for any of these conditions. I acknowledge that the risks of using Therapeutic Cannabis under these circumstances could be severe.

I understand that my PATC (Prime Alternative Treatment Centers) does not suggest nor condone that I cease treatment of medications that stabilize my mental or physical condition.

I am not pregnant, intending to become pregnant, or breastfeeding.

I certify that I have read this Therapeutic Cannabis Program Patient Agreement and declare that the information contained herein is true, correct, and complete.

Patient Signature: _____ Date: _____

Patient Name: _____