Living Green Resource Center

Patient Information

Last Name: _____ First Name: _____

DOB: _____ Sex: _____

Preferred Phone: _____ Email: _____

Primary Care Provider (PCP): _____

For what condition are you seeking to address with a Medical Cannabis Card?

_____

Do you have any food allergies, food sensitivities, or digestional issues? If so, please list below:

_____

Do you have any drug allergies? If so, please list below:

_____

Please list any current medications you are taking, and reason for use:

_____

_____

Operations and/or Hospitalizations: (Please list surgeries and/or hospitalization reasons and dates)

_____

_____

Are you currently under any psychiatric care? If so, for what diagnosed conditions?

_____

Are you currently on any anti-depressant medications? _____ If so what kind? _____

If you are experiencing pain, on a scale of one to ten, with ten being the worst and one being no pain, how would you rate your current pain level? _____

Are you currently taking any opiod medications? _____ If so what kind? _____

Do you experience stress or anxiety on a daily basis? _____

How many hours of sleep do you get a night? _____

How many hours of exercise do you get a day / week? _____ / _____

Does your daily diet consist of fresh fruits and vegetables? _____

Do you smoke? _____

Do you consume alcohol daily? _____ Weekly? _____

How much water do you consume daily? _____ Tap or bottled _____

Do you have daily exposure to chemicals and fragrances in your home via cleaning supplies, or personal care items _____