MAITRI

PATIENT INTAKE FORM

NAME: ______________________________ DOB: ____/____/______

PHONE: ______________ EMAIL: ______________________________

ADDRESS: ____

BEFORE WE BEGIN

- **May we contact you for follow up?** ☐ **Yes** ☐ **No**
- **What is your preferred method of contact?** ☐ **Email** ☐ **Phone**
- **Would you like to join our email list to receive updates about new products and events?** ☐ **Yes** ☐ **No**
- **How did you hear about Maitri?** ☐ **Friend/Family** ☐ **Social Media** ☐ **Newspaper/Magazine Ad** ☐ **Physician** ☐ **Other (please explain)** ______________________________

MEDICAL HISTORY

Please check any Medical Conditions that apply.

☐ **Anxiety Disorders** ☐ **ALS** ☐ **Autism** ☐ **Cancer** ☐ **Crohn's Disease** ☐ **Dyskinetic Disorders**
☐ **Epilepsy** ☐ **Glaucoma** ☐ **HIV/AIDS** ☐ **Huntington's Disease** ☐ **Inflammatory Bowel Disease**
☐ **Intractable Seizures** ☐ **Multiple Sclerosis** ☐ **Neurodegenerative Diseases** ☐ **Neuropathies**
☐ **Opioid Use Disorder** ☐ **Parkinson's Disease** ☐ **PTSD** ☐ **Severe Chronic Pain** ☐ **Sickle Cell Anemia**
☐ **Spinal Spasticity** ☐ **Terminal Illness** ☐ **Tourette Syndrome**

Please check any additional Medical Conditions not listed above.

☐ **Asthma** ☐ **Cholesterol** ☐ **Diabetes** ☐ **Heart Disease** ☐ **High Blood Pressure** ☐ **Kidney Disease** ☐ **Peptic Ulcer**
☐ **Psoriasis** ☐ **Thyroid Disease** ☐ **Other** ______________________________

- **Do you have, or is there any family history of schizophrenia or mental illness?** ☐ **Yes** ☐ **No**
- **Are you pregnant?** ☐ **Yes** ☐ **No** **Are you trying to become pregnant?** ☐ **Yes** ☐ **No**

CURRENT MEDICATIONS

- **Do you have any drug allergies?** ☐ **Yes** ☐ **No** **If so, to what?** ______________________________

____

- **Please list any medications you are currently taking. Include non-prescription medications, vitamins and/or supplements (use back page if additional space is required):** ______________________________

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MAITRI

PATIENT INTAKE FORM

MEDICAL MARIJUANA TREATMENT

The positive outcomes I hope to achieve are:

☐ **Symptom Relief** ☐ **Reduce Pain** ☐ **Improve Sleep** ☐ **Improve Mood** ☐ **Increase Appetite** ☐ **Reduce Spasms** ☐ **Reduce Inflammation** ☐ **Seizure Control** ☐ **Prevent Degeneration** ☐ **Decrease use of pain/other medications**
☐ **Other (please explain)** ____________________

Please check the negative symptoms you are experiencing:

☐ **Abdominal Pain/ Cramping** ☐ **Anxiety** ☐ **Depression** ☐ **Difficulty Falling or Staying Asleep** ☐ **Fatigue** ☐ **Hyperactive Bowels** ☐ **Migraine** ☐ **Muscle Spasm** ☐ **Nausea** ☐ **Ocular Pressure** ☐ **Pain** ☐ **Poor Appetite** ☐ **Seizures** ☐ **Tremors** ☐ **Inflammation**

Please check the severity of your most bothersome symptom:

(Where 0 is no symptoms and 10 is the worst you can imagine) ☐ **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

What are your primary concerns or questions, if any:

☐ **Administration** ☐ **Cost** ☐ **Dosing** ☐ **Efficacy** ☐ **Mechanism of Action** ☐ **Safety** ☐ **Travel** ☐ **Side Effects** ☐ **None**
☐ **Other (please explain)** ____________________

LIFESTYLE

- **Do you smoke tobacco?** ☐ **Yes** ☐ **No**
- **Do you drink alcohol?** ☐ **Yes** ☐ **No**
- **Do you drink coffee, tea or soda?** ☐ **Yes** ☐ **No**
- **Do you have any dietary restrictions?** ☐ **Yes** ☐ **No** **If yes, please describe:** ____________________

____

- **Have you used marijuana prior to this visit?** ☐ **Yes** ☐ **No** **(If no, skip to next section)**
- **If Yes, how often?** ☐ **Daily** ☐ **Weekly** ☐ **Monthly**
- **What consumption method?** ☐ **Vaporizer** ☐ **Tincture** ☐ **Oils** ☐ **Concentrate** ☐ **Topical** ☐ **Transdermal** ☐ **Oral**
- **How much? (e.g. 1/4 oz per week, 2 puffs once daily)** ____________________
- **Which strains work well?** ____________________
- **Which strains do not work well?** ____________________
- **Have you had any negative effects from Medical Marijuana?** ☐ **Yes** ☐ **No**
  If yes, please describe: ____________________
- **What other therapies have you tried?** ☐ **Medications** ☐ **Surgery** ☐ **Chiropractic** ☐ **Physical Therapy** ☐ **Alternative** ☐ **Other** ____________________

MY MEDICAL MARIJUANA TREATMENT CHOICES

My preferred method of consumption:

☐ **Vapor/Nebulizer** ☐ **Topical Form** ☐ **Liquid Form** ☐ **Oil** ☐ **Pill** ☐ **Tincture**

My preferred level of Psychoactivity (changes in mood or consciousness) is:

(DAYTIME USE): ☐ **None** ☐ **Low** ☐ **Medium** ☐ **High** **(NIGHTTIME USE):** ☐ **None** ☐ **Low** ☐ **Medium** ☐ **High**