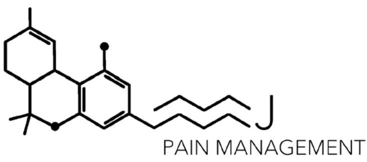

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Patient Registration

Date:

Last Name: First Name:

Date of Birth: Gender: Last 4 Digits of SS#:

Physical Address
Address: Address (Line 2):

City: State: NJ Zipcode:

County: Municipality:

Mailing Address *Same as Physical Address*
Address: Address (Line 2):

City: State: NJ Zipcode:

Email:

Phone (mobile): Phone (secondary):

Apple Android

Primary Physician:

Referred by:

Preferred ATC:

I acknowledge that MMJ Pain Management and my physician do not diagnose, treat patients, or prescribe medication. You must be under the care of another physician who has diagnosed you and is treating you.

MMJ Pain Management and my physician will review your records and evaluate you. If you meet state requirements, we will certify you to enroll in the medical marijuana program.

We do not issue medical marijuana ID cards, but we will help you enroll in the program. Also, we do not dispense medical marijuana.

Once you get certified you must keep your certification up by continuing in to be evaluated by your physician.

I acknowledge that the fee structure has been explained to me and the only methods of payment accepted is credit card. Fees are collected prior to each visit

____

Patient Signature

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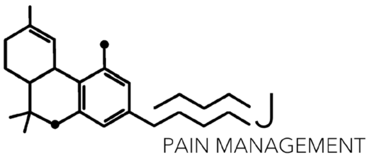

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HIPAA Release of Information Authorization Form

I, ____, hereby authorize MMJ Pain Management,
Print name of patient
its employee and agents to release my personal health information relating to the diagnosis treatment and health care services provided or to be provided to me.

This authorization for release of information covers the period of healthcare from today's effective date until authorization is rescinded in writing.

I further understand that this authorization is voluntary and that you may refuse to sign this authorization.

I understand I have the right to revoke this authorization in writing at any time.

I also have the right to exclude authorization for the following items:

____

____

____

____

____

______________________________________ ______________________________________
Print name of patient Signature of patient

______________________________________ ______________________________________
Print name of witness Signature of witness

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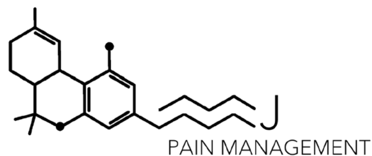

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Physician / Patient Disclaimer and Release Form

I, ________________________________, being of sound mind, have read and understand the following:
Print name of patient

1. My physician has evaluated my medical condition / conditions and confirmed that I am qualified to be enrolled in the New Jersey Medicinal Marijuana Program.
2. My physician has explained to me that marijuana can interact with many other medicines and ingested substances. Therefore, since the scope of these interactions are unknown and may vary even in the same individual, I should not use marijuana while taking any other mind-altering substances or medicines *without first consulting with my physician*.
These include, but are not limited to:
   - Alcohol
   - Antidepressants (SSRIs, Tricyclic, Atypical)
   - Antipsychotics
   - Sedatives (Valium, Ativan, Clonopin)
   - Opiates and other analgesics (tramadol, Percocet, Vicodin, Methadone, OxyContin)
   - Antihistamines (Benadryl)
   - Hypnotics (Ambien, Lunesta, Valium)
   - Anxiolytics (Xanax, Ativan)
   - Asthma medicines and inhalers
   - Chronic Obstructive Pulmonary Disease medicines and inhalers

3. I fully understand that marijuana remains illegal under federal law.
4. I agree not to drive under the influence of medicinal marijuana or operate any machinery or equipment.
5. My physician and office staff will not be held responsible in any way for any untoward effects, directly or indirectly related to my use of medicinal marijuana.
6. My physician has explained to me that THC (delta-9-tetrahydrocannabinol) and all other constituents of marijuana have not undergone rigorous scientific studies or empiric studies to determine all the effects and potential effects it can have on me, my health, my behavior, and my lifestyle.
7. I understand that possible consequences of marijuana use include but may not be limited to: Depression or worsening depression; Frank psychosis; Anti-social behaviors; and other complications which may lead to death in susceptible individuals.
8. I accept all responsibility for any and all fallout from my decision to use medicinal marijuana.
9. I understand and agree to use medicinal marijuana only in private locations and adhere to all NJMMP patient rules and regulations.
10. I will not share or sell my medicinal marijuana with / to family, friends, strangers, or any other person or persons. Possession, use, and sale of medicinal marijuana remains illegal under federal law, the state may not be able to protect you from prosecution by the federal government.

____ ______________________
Patient Signature Date

____
Physician Signature

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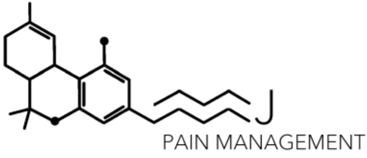

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Name: Date:

Chief Complaint or Qualifying Diagnosis:

If you have chronic pain:

1. Location of pain:
2. Severity of pain on a scale of 1 to 10:
3. When pain began?
4. Was there an event or condition that caused the pain?
5. What treatments have you received?

____
____
____

If you have anxiety:

1. When did it begin?

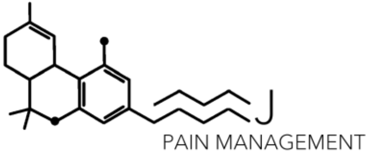
2. What treatments have you received?

All other qualifying diagnosis:

1. When did it begin?
2. What treatments have you received?

3. What symptoms cause the most discomfort?

____
____
____



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Social History

What is your marital status? Single married divorced widow

Do you smoke? Yes No How many packs per day?

Do you drink alcohol? Yes No How much per week?

Do you take street drugs? Yes No What?

Medical History

Medication:
Are you taking any medication now? _____ YES _____NO *If yes fill out chart.*

Drug Name	Dose	Start date	Reason
1.			
2.			
3.			
4.			
5.			
6.			
Have you experienced any side effects?			

Allergies:
Are you allergic to any Medications? _____ YES _____NO *If yes fill out chart.*

Drug name	Date of reaction	Type of reaction
1.		
2.		
3.		

Surgical History:
Please list any surgery you have had no matter how long ago or small it was:

Surgery	Date
1.	
2.	
3.	
4.	
5.	
6.	

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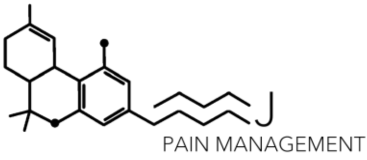

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Family History

Do any of your blood relatives have any of the following diseases?

Please check if yes or no.

Disease	Yes	No	Relation
Bleeding Disorder			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Stroke			

Doctors Notes

____
____
____
____
____

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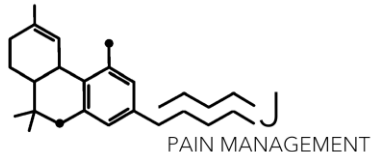

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Review of Systems

Constitutional:
- Eating Disorder
- General Weakness

Hematology/ Lymphatic:
- Easy bruising
- Swollen lymph nodes
- Anemia
- Poor Blood Clotting

Cardiovascular:
- Heart attack
- High blood pressure
- Blood clot or embolism
- Heart murmur
- Chest Pain
- Difficulty Breathing

Respiratory:
- Asthma
- Chronic Bronchitis
- Emphysema COPD

Musculoskeletal:
- Arthritis
- Painful or swollen joints

Gastrointestinal:
- Irritable bowel
- Nausea or vomiting
- Diarrhea or constipation
- Chronic indigestion

Urinary Tract:
- Kidney stones
- Frequent bladder infections

Endocrine:
- Diabetes
- Thyroid disorder

Neurologic:
- Epilepsy or seizures
- Stroke
- Migraine headaches

Psychiatric:
- Anxiety
- Depression

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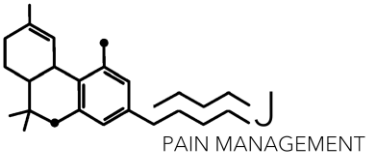

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Anxiety Questionnaire

Do you have any of the following?

	Yes	No
A sense of worry that is difficult to control		
Restlessness or feeling keyed up or on edge		
Easily fatigued		
Difficulty concentrating		
Irritability		
Muscle tension		
Sleep disturbance		
Pounding or racing heart		
Sweating or cold, clammy hands		
Feeling jumpy or restless		
Trembling, twitching, or shaking		
Having a tough time catching your breath		
Feeling a fullness in the throat or chest		
Feeling dizzy or lightheaded		
Having stomach aches or nausea		

You must have at least three of the above symptoms to qualify for the diagnosis of Anxiety
OR
Have a doctor's note confirming the diagnosis of anxiety.

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Name:

DOB:

Date:

GAD-7 Anxiety Assessment

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Total score: ______

0-4: negative anxiety screen
5-9: mild anxiety
10-14: moderate anxiety
15+: severe anxiety

Reference:

Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7. doi: 10.1001/archinte.166.10.1092. PMID: 16717171.