BURNS
INTEGRATIVE
WELLNESS CENTER

Personal Information

Date_____

Name_____ Date of Birth_____ Age_____

Height_____ Weight_____ Gender: Male / Female

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____

Would you like to subscribe to our newsletter (no more than 1-2 emails per month)? YES / NO
(Our newsletter includes health-related articles, Medical Marijuana announcements, and healthy recipes.)

How did you hear about us? _____

MMJ Card Information

Please ensure the following information is accurate and legible as it will be used to submit your card application to the Health Department.

Residential Address (NO PO Box):

Street: _____ (NO PO Box)

City: _____ Zip: _____

Mailing Address: ____ Same as residential ____ Alternate Address

Street: _____

City: _____ Zip: _____

Veteran: ____ Yes ____No

Social Security Disability: ____ Yes ____No

Are you on Food Stamps? ____ Yes ____No

Would you like to cultivate? ____ Yes ____No

(In order to qualify for cultivation, you must live more than 25 miles from an operating dispensary.)

By signing below, I attest that the information I provided above is accurate, and I agree to be responsible for any potential fees if I need to change the information with the Health Department.

_____ _____
Patient Signature Date

Medical History

Current medical complaint: (List the medical problems for which you use or would like to use medical marijuana; please provide details. Let us know if you need more space.)

_____

_____

_____

Who takes care of you for your medical problems (doctor, chiropractor, acupuncturist, massage therapist, psychologist or counselor, etc.)? Please give the name and tell us when you were last seen.

_____

_____

_____

Medications: List all of your medications (include prescription, herb, and over-the-counter).

_____

_____

List any medication you are allergic to:_____

_____

Other treatments (check any other treatments you use for your condition):

____surgery ____physical therapy ____chiropractic ____massage ____herbal therapy

____counseling ____exercise ____other_____

Do you have or have you ever had any of the following medical problems?

____Asthma/Lung Disease ____Cancer ____HIV/AIDS ____Diabetes ____Hepatitis

____Epilepsy/Seizures ____Stroke ____Liver Disease ____Kidney Disease

____High Blood Pressure ____Heart Disease ____Sleep Disorders (sleep apnea, insomnia)

____Substance Abuse ____Intestinal Disorders (IBS, ulcers) ____Multiple Sclerosis

____Mental health problems ____ADD/ADHD

Female Patients Only:

Are you pregnant? Yes/No Are you currently breastfeeding? Yes/No

Surgical History

Please list the surgeries that you have had:

_____

_____

_____

Drug and Alcohol History

Do you currently use: Tobacco Yes/No number of cigarettes per day _____

Alcohol: Yes/No number of drinks per week _____

Other substance use history:

_____ Cocaine/Meth

_____ Opiates/Prescription opiates/heroin/methadone

_____ Hallucinogens/ecstasy/LSD/mushrooms

_____ None

Would you like help quitting? Yes / No / NA

Marijuana History

Have you been evaluated by another physician for medical marijuana? Yes/No

If yes, where and when:

_____

_____

Do you use marijuana to reduce or eliminate the use of any medications that have been prescribed for your medical condition? Yes/No

If yes, which medication have you reduced or eliminated and why?

_____

_____

Marijuana History (cont.)

How often do you use marijuana?

____ every day or almost every day

____ about 1-2 times per week

____ more than once a month

What is your preferred method of using marijuana?

____ smoke ____vaporizer ____ingested ____topical

How effective is marijuana for your medical problem?

____ very effective ____ effective ____ only somewhat effective

I understand that the information I have been asked to provide is for the diagnosis and treatment of the medical condition for which I am seeing the physician today, and that if I have not accurately and completely disclosed the requested information, it may adversely impact the physician's ability to diagnose my condition and recommend appropriate treatment. I certify that the information in this questionnaire is accurate and complete.

_____ _____

Patient Signature Date

Burns Integrative Wellness Center
Important Patient Acknowledgments

By signing this page, you are acknowledging that:

- The physician, staff, and/or representatives of Burns Integrative Wellness Center are neither providing nor dispensing medical marijuana.
- Burns Integrative Wellness Center's physician will NOT be providing or discussing information regarding dispensary, co-op, delivery service, or any other way to obtain marijuana.
- The physician, staff, and representatives of Burns Integrative Wellness Center are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider.
- Should an approval be made for my medical use of cannabis, there is a renewal date specified by the physician. It is my responsibility to see the physician to re-evaluate possible continuance of cannabis use beyond the term of the approval.
- I am a resident of Arizona and have not misrepresented any information to Burns Integrative Wellness Center.
- I am not an agent of law enforcement, state, or federal government here for the purpose of investigation or entrapment.
- I am not recording any portion of my visit with Burns Integrative Wellness Center nor do I possess any recording equipment. I understand Burns Integrative Wellness Center does not approve such action.

Patient Signature: _____ Date: _____

Burns Integrative Wellness Center
Informed Consent

By signing below, you acknowledge that you have been informed of and understand the following:

I am being evaluated for a physician's recommendation for marijuana. The physician will make this determination based, in part, on the medical information I have provided. I have not misrepresented my medical condition in order to obtain this recommendation and it is my intent to use marijuana only as needed for the treatment of my medical condition, not for recreational or non-medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use, sale/purchase and/or distribution of marijuana.

I must be a Arizona resident to obtain an approval or recommendation for the use of cannabis (medical marijuana) under Arizona's AMMA (A.R.S. Title 36, Chapter 28).

Marijuana has not yet been approved by the Food and Drug Administration. Therefore, marijuana sold for medical use is not subject to any standards, quality control, or other oversight. Marijuana may contain unknown quantities of active ingredients (i.e., can vary in potency), impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

The use of marijuana can affect coordination, motor skills, and cognition, i.e., the ability to think, judge, reason and act. While using marijuana, I should not drive, operate heavy machinery, or engage in any activities that require me to be alert and/or respond quickly. I understand that if I drive while under the influence of marijuana, I can be arrested for "driving under the influence."

Potential side effects from the use of marijuana include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low blood pressure, impairment of short-term memory, euphoria, difficulty in completing complex tasks, suppression of the body's immune system, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression, and/or restlessness. Marijuana may exacerbate schizophrenia in persons predisposed to that disorder. In addition, the use of marijuana may cause me to talk or eat in excess, alter my perception of time and space, and impair my judgment.

I understand that using marijuana while under the influence of alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.

I understand that I may contact my primary care physician or 911 if I experience any of these side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. I will also contact my primary care physician or 911 if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends. (Continued)

Initial: _____

INFORMED CONSENT (continued)

Smoking marijuana may cause respiratory problems and harm, including bronchitis, emphysema, and laryngitis. In the opinion of many researchers, marijuana smoke contains known carcinogens (chemicals that can cause cancer) and smoking marijuana may increase the risk of respiratory diseases and cancers in the lung, mouth, and tongue. In addition, marijuana smoke contains harmful chemicals known as tars. If I begin to experience respiratory problems when using marijuana, I will stop using it and report my symptoms to a physician. The physician will inform me of alternatives to smoking marijuana.

The risk, benefits, and drug interactions of marijuana are not fully understood. If I am taking medication or undergoing treatment for any medical condition, I understand that I should consult with my treating physician(s) before using marijuana and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating physician(s).

Individuals may develop a tolerance to, and/or dependence on, marijuana. I understand that if I require increasingly higher doses to achieve the same benefit or if I think that I may be developing a dependency on marijuana, I should contact my primary care physician or seek professional help. Signs of withdrawal can include: Feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances, and unusual tiredness.

Symptoms of marijuana overdose include, but are not limited to: nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in the hands, feet, arms, or legs, anxiety attacks, and incapacitation. If I experience these symptoms, I should contact my primary care physician, dial 911 or go to the nearest emergency room.

If Burns Integrative Wellness Center subsequently learns that the information I have furnished is false or misleading, the recommendation for marijuana may be revoked. I agree to promptly meet with and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided.

I will have the opportunity to discuss these matters with the physician and to ask questions regarding anything I may not understand or that I believe needs to be clarified.

Patient Signature: _____ Date: _____

Burns Integrative Wellness Center
Consent for Use or Disclosure of Health Information

We here at Burns Integrative Wellness Center are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

- We may need to use your health information within our practice for quality control or other operational purposes such as recall notices, reminder calls, and treatment news.

Burns Integrative Wellness Center, its staff or employees, may from time to time schedule appointments for other healthcare providers, when requested. These providers are not partners or contractors of Burns Integrative Wellness Center. All health and patient information disclosed to Burns Integrative Wellness Center, its employees or staff, shall remain confidential and we will ensure that all federal and state laws pertaining to confidentiality of patient health information, including HIPAA, are complied with.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

By signing below, I hereby acknowledge that I have read and understood how my health information may be used and/or disclosed. This Acknowledgement will be filed with my records.

Patient Name (print): _____

Patient Signature: _____

Date: _____

Burns Integrative Wellness Center
Agreement to Provide Medical Records or Establish Care

I hereby agree to provide medical records dated within the last 12 months that support my qualifying condition.

If I don't have or cannot provide said records, I agree to establish care at Burns Integrative Wellness Center.

In order to establish care, I will return for at least one follow-up visit with a doctor at Burns Integrative Wellness Center. In addition, I understand that I may be required to obtain imaging or lab results in order to support the diagnosis.

Patient Name (print): _____

Patient Signature: _____

Date: _____