101 Cambridge Street, Suite 310
Burlington, MA 01803
O: 781 328 4488
F: 888 204 0053

NEW PATIENT HEALTH HISTORY

Name: _____Date of Birth:_____ Age: _____

May leave a Generic Message (Cell, Home, Email) YES NO Preferred Phone Number: (Enter Below)

May leave a Detailed Message (Cell, Home, Email) YES NO _____

Place Check next to any of the following symptoms that you have been experiencing:

Weakness: _____ Cachexia: _____ Wasting syndrome: _____ Intractable pain: _____Nausea: _____
Impairing strength or ability: _____

Place Check next to any of the following medical conditions you have been diagnosed with:

Cancer: ___ AIDS: ___ Parkinson's Disease: ___Glaucoma: ___ ALS: ___ Multiple Sclerosis: ___ PTSD:___
Hepatitis C:___HIV Positive: ___ Crohn's Disease: ___ Other(specify):_____,

Place Check next to any of the following major life activities/categories that are affected by your condition and/or symptoms.

Mental: _____Emotional: _____Social: _____ Employment: _____ Recreation: _____Physical: _____

FOR YOUR MOST PRESSING HEALTH CONCERN, PLEASE DESCRIBE THE FOLLOWING:

What are your current symptoms (be as descriptive as possible)

_____

_____

_____

_____

What makes it better, what makes it worse?

_____

_____

Do the symptoms that you are currently experiencing improve with marijuana use? If so, please explain.

_____

_____

How did this condition start?

_____

_____

_____

What type of workup have you had (doctors seen, tests performed, etc.)?

_____

_____

_____

What treatments have you tried? How well have they worked?

_____

_____

_____

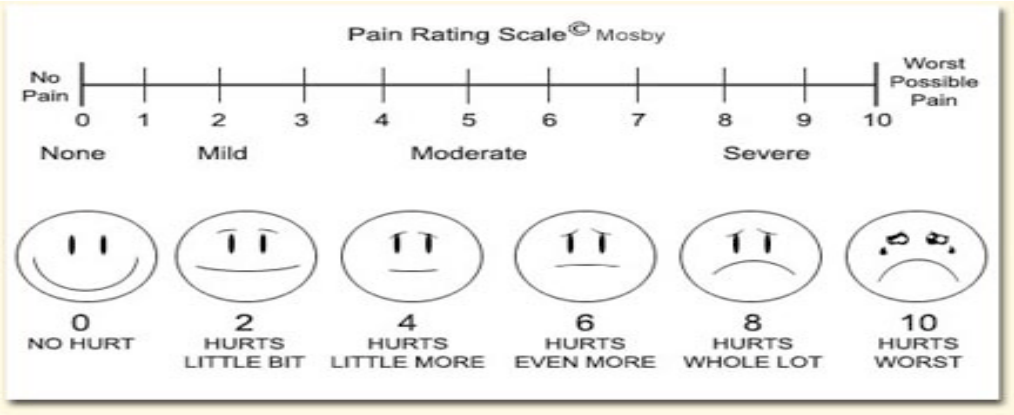
Are you in Pain? _____

Where is your Pain?

_____

_____

If in pain please indicate your pain level on the chart below by circling the appropriate number on the scale



PAST MEDICAL HISTORY: Please list all major illnesses, injuries, traumas (including emotional), and surgeries w/ year

_____

_____

CURRENT MEDICAL CARE: Primary Care Provider (name, practice name or location):

_____

Approximate date of last physical examination: _____ by whom? _____

Would you like us to send a copy of your office visit note to your PCP or other providers? (Circle) YES NO

I am or have been treated by a: Talk therapist _____ Social worker _____ Psychiatrist _____ Pain specialist_____

Heart specialist_____ Nerve specialist_____

Other health care professional(s) you are seeing and for what conditions: _____

_____

CURRENT MEDICINES, SUPPLEMENTS, HERBS (w/ dosage please):

_____

_____

_____

_____

ALLERGIES? (include reactions to medicines): _____

LIFESTYLE:

I have finished: Middle School____ High School ____ College ____ Post-Graduate Degree ____

I am: Employed____ Unemployed____ Disabled____ Other_____

How many hours of sleep do you get a night? _____ Trouble sleeping or sleeping too much? _____

How many cups or glasses do you drink per day: water:_____ milk:____ caffeinated beverages:_____

How many alcoholic beverages do you drink per week: _____Tobacco: _____ Drugs_____

What substances have you used in the past:

Cocaine_____ Heroin_____ RX drug abuse_____ Mushrooms_____ Acid_____ Ecstasy_____

ETOH_____ Other_____

How much exercise per week (what kind?) _____

What do you do for fun? _____

Any recent major life changes? _____

FAMILY MEDICAL HISTORY: (please list any conditions that run in the family, indicate if alive or deceased)

Mother_____

Father _____

Siblings_____

CANNABIS HISTORY

Are you currently using marijuana to alleviate any symptoms that you are experiencing? Yes No

If so, which symptoms:_____

If you were not using cannabis to treat your symptoms, how would you

feel?_____

At What Age did you first use Cannabis?_____

Dosage (i.e. 2-3 puffs three times daily, or ¼ ounce per week)

_____

If you smoke/vaporize, how many inhalations do you use in one sitting?_____

Delivery System (i.e. pipe, joint, vaporizer, tincture, etc.)

_____

High/Low Quality? Strain?

_____

Have you had any adverse affects from cannabis?

_____

Have you ever had a reaction from cannabis? (circle) anxiety, depression, paranoia, other_____

"REVIEW OF SYMPTOMS" Check off any of the following symptoms you have/had experienced **in the PAST 2 WEEKS**:

GENERAL:

___ weight change
___ tired/weak
___ dizzy/fainting
___ fever/chills

HEAD:

___ headaches
___ glaucoma
___ cataracts
___ blurry vision
___ hearing aids

___ eye pain
___ hearing loss
___ noise in ears
___ earaches
___ voice change

___ runny nose
___ stuffy nose
___ nosebleeds
___ sore throats
___ swollen glands

___ painful teeth
___ bleeding gums
___ dentures
___ goiter

RESPIRATORY:

___ cough ___ cough with phlegm ___ cough with blood ___ wheezing ___ short of breath

HEART & CIRCLATION:

___ high blood pressure ___ heart races or skips beats ___ chest pain ___ short of breath after climbing steps
___ short of breath while laying in bed ___ legs swell ___ legs hurt or cramp when walking ___ varicose veins

DIGESTIVE:

___ trouble swallowing ___ heartburn ___ poor appetite ___ nausea ___ vomiting (with blood?) ___ diarrhea ___ constipation ___ excess belching or passing gas ___ change in stool (with blood?)
___ hemorrhoids ___ rectal pain ___ jaundice ___ gallbladder pain ___ abdominal pain & swelling
URINARY:
___ burning with urination ___ frequent urination ____ change in urine stream (with blood?)
___ frequent urinary infection ___ lose urine if you cough or sneeze ___ kidney stones
MUSCULOSKELETAL:
___ pain in muscles or joints ___ morning stiffness ___ backache ___ sciatica ___ low back pain ___ arthritis
___ gout ___short leg ___ wear a shoe lift ___ scoliosis __muscle spasms
NEUROLOGICAL:
___ blackouts ___ seizures ___ numbness or loss of sensation ___ tingling or "pins and needles"
___ tremors or other involuntary movements ____ weakness in arms or legs ___ trouble walking
OTHER:
___ heat or cold intolerance ___ excessive sweating ___ excessive thirst or hunger ___excessive urination
___ nervousness ___ tension ___ difficulty with memory ___ skin changes / rash

MENTAL HEALTH:

___racing thoughts ___difficulty concentrating ___bipolar disorder ___seeing weird things
___hearing voices in your head ___un-realistic fears ___guilty feeling
___poor coordination ___anger problems ___thoughts of killing myself or others ___risky driving
___casual sex ___moodiness ___feeling empty inside ___"hyper" ___unstable relationships
___no friends ___Feeling alone ___Addictions ___Anxiety ___Panic ___Obsessive thoughts
___Cutting myself ___eating disorder ___people trying to harm or harass me ___depression ___nervousness
___not needing sleep ___easily distracted ___ feeling of being followed ___ people are conspiring or out to get you

MALE PATIENTS:

___ urinary stream slower, smaller or split ___ lumps or pain in testicles ___ erection problems ___ sores

FEMALE PATIENTS:

___ breast tenderness or pain ___ breast lumps ___ nipple discharge ____ hot flashes
___ change in menstrual cycle, bleeding or pain ___ vaginal sores or discharge ___ painful intercourse

Age your periods began: _____ Number of days period lasts: _____ Date of last period _____

Number of pregnancies _____ Number of deliveries _____ Age at menopause: _____

Birth control method: _____ ;

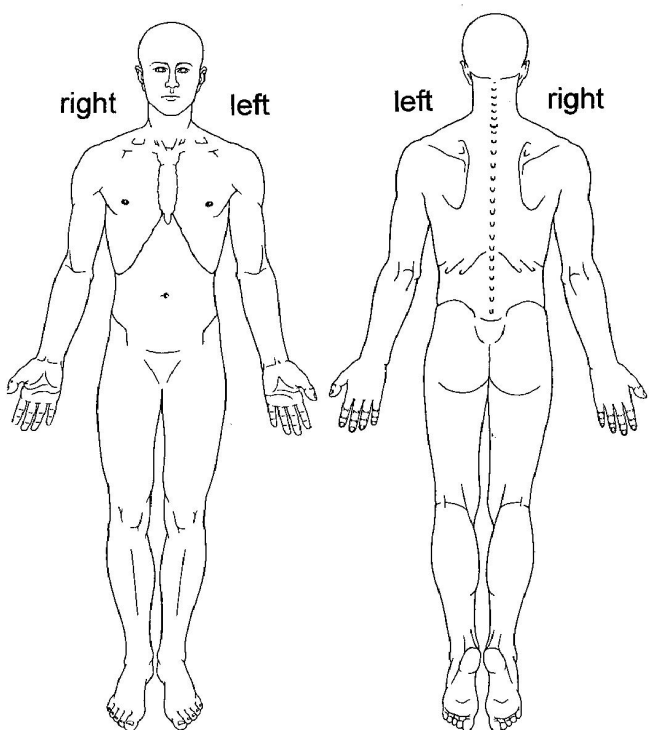
PAIN PATTERNS CHART ---------->>>>

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



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NEW PATIENT INFORMATION & CONSENT FORM

Patient's name_____ M____ F___ Birth Date _____

Patient's address _____

_____

Email:_____

Telephones: home_____ work_____ cell _____

single___ married___ other___ children _____

Occupation _____

Patient's employer or school _____

Patient's Primary Care Physician (and/or Referring Physician) _____

Do you have Medicare as an insurance provider (please check): Yes_____No_____

Emergency Contact Info:

Name: _____ Relationship: _____ Phone: _____

Referred by: _____

I, _____ understand that payment for services by this office is solely my responsibility, regardless of any insurance coverage I may have. I authorize the release of any medical or other information necessary to process insurance claims, or a release of records to medical review agencies as required by law. I voluntarily and knowingly consent to and request outpatient treatment, which may encompass diagnostic tests and medical treatments deemed appropriate by the treating physician. I understand that such services are to be performed by the attending physician or by assistants designated by said doctor. I further authorize and consent to assistants and other personnel, to undertake this service and care as indicated by my attending physician.

_____ _____

Signature of Patient, Parent or Guardian Date

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CONSENT TO TREATMENT WITH MARIJUANA FOR MEDICAL PURPOSES

I, _____, ("Patient") am requesting Thor Agustsson, D.O. or another Integr8 Massachusetts, Physician (the "Physician") to certify (*circle one)* **me /my child/ my legal ward** as a qualifying patient under the Massachusetts Medical Marijuana Law (105 CMR: Department of Public Health) and to treat Patient's debilitating medical condition as Patient uses marijuana for medical purposes. In requesting the Physician to continue treating Patient as Patient uses marijuana for medical purposes, I assume full responsibility for any and all risks of this action related to Patient's current medical condition.

I understand that marijuana is not approved by the Federal Food and Drug Administration for medicinal purposes and may contain unknown quantities of active ingredients and may potentially contain contaminants and/or impurities. I understand that the Physician may not be knowledgeable of all the associated risks involved in the use of a non-FDA approved substance such as marijuana. I acknowledge that there is controversy in the medical/scientific literature available regarding the usage of marijuana for medical purposes and that more research is currently being conducted.

I understand that although the Massachusetts law has approved the limited use of marijuana for medical purposes, its use is not approved under federal law, and that the current and future enforcement action of federal law enforcement officials is uncertain.

Date: _____

_____

Signature of Patient or Patient's Parent/Legal Guardian

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies and Procedures from Integr8 Massachusetts.

I authorize Integr8 Massachusetts to review and discuss my medical information with the following individual(s): (Leaving blank will only allow us to speak with you directly.)

_____ _____
Full Name Relationship & Phone Number

_____ _____
Full Name Relationship & Phone Number

When a Medical Marijuana Certification is requested to be verified with a verification code, I agree to allow Integr8 Massachusetts to provide the following information: first and last initials, date of birth, and the certification expiration date. A verification request may occur through phone, mail, and/or Internet.

For a copy of our privacy practice can be found on our website:
http://www.integr8mass.com/policies

_____ _____
Signature of Individual Date

In the event this request is made by the individual's personal representative:

_____ _____
Signature of Patient or Patient's Parent/Legal Guardian Date

_____
Legal Authority of Personal Representative