Affinity dispensary

Initial Patient Intake Form

Patient Information

Today's Date: _____/_____/_____ Date of Birth: _____/_____/_____ Age: _____

Patient Name (last, first, middle initial)**:** _____ Gender: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Cell: _____

Email: _____ ☐ Personal

I would like to be included in email updates as they become available: ☐ Yes ☐ No

Are you a Veteran? ☐ Yes ☐ No

Are you a Senior Citizen (65 or over)? ☐ Yes ☐ No

Do you have a Caregiver? ☐ Yes ☐ No

Caregiver's Name: _____ Caregiver's Phone #: _____

A Registered Caregiver is a person chosen by the patient to act as their agent in obtaining their medication at the dispensary. If you feel that you need a caregiver, please contact your qualifying physician.

In Case of Emergency

Name of local friend or relative (not living at same address): _____Relationship to Patient: _____

Home Phone**:** _____ Work/Cell Phone: _____

Medical History

Certifying Physician: MD/APRN_____ Phone Number: _____

Qualifying Condition for Medical Cannabis? _____

Note: Additional conditions will be added over time, please check the Department of Consumer Protection website for changes to the list at www.ct.gov/dcp.com.

Have you or any members of your family suffered from the following?

Schizophrenia ☐ Yes ☐ No

Psychosis ☐ Yes ☐ No

Are you currently pregnant or nursing? ☐ Yes ☐ No

Are you planning on becoming pregnant within the next six months? ☐ Yes ☐ No

It is the patient's responsibility to notify Affinity Dispensary if there are any changes. **Patient Initials: _____**

Do you smoke tobacco? ☐ Yes ☐ No

Do you have Active Unstable Ischemic Heart Disease? ☐ Yes ☐ No

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Current Medications/Vitamins/Supplements

Tell us about any other medications, vitamins or supplements that you are currently taking:

Current Medication	Dosage

Do you have any allergies? _____

Medical Marijuana Experience

On a scale of 1 to 5, how familiar are you with marijuana?

Never used it/ Not sure	Tried a few times in the past	Vape/consume a couple times a year	Vape/consume a couple times a month	Vape/consume daily/regularly
1	**2**	**3**	**4**	**5**

Have you previously used marijuana or medical marijuana (MM) to treat your condition? ☐ Yes ☐ No

What types of MM have been the most effective in relieving your condition? *(Check all that apply).*

☐ Sativa ☐ Indica ☐ Hybrid ☐ CBD Dominant ☐ Unsure

What consumption methods are you most interested in today? *(Check all that apply)*

☐ Flower ☐ Pre-Rolls ☐ Vape ☐ Edible ☐ Sublingual/Drops ☐ Topical ☐ Capsules/Tablets

☐ Concentrates ☐ Unsure

Are there any specific products that have worked well for you in the past? *(Please list).*

_____

_____

_____