Independent Wellness Center
1000 W. Apache Trail, Suite #108, Apache Junction, AZ 85120
Phone# 480-983-5060 Fax # 480-983-5070

PATIENT INTAKE

***Welcome t*o Independent Wellness Center**. In order to provide you with the best health care and assist you with other details of our clinic, we have provided the following information. We appreciate your assistance in completing the intake paperwork.

Appointment Date_____

Time_____

Name:_____DOB:_____Age:_____

Address:_____

City:_____State:_____Zip:_____

Phone Number:_____Alternate:_____

Occupation:_____

Email (For your APPROVAL from the state)_____

Emergency Contact:_____
Name Title Phone

How did you find our Clinic?_____

Please list the concerns you have that you would like to discuss with the doctor

1.
2.
3.
4.

Please list how you have addressed your concerns:

1. 2.
3. 4.

HOSPITALIZATIONS / SURGERIES:

INCIDENT	**DATE**
1. _____	_____
2._____	_____

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Mark All Special Studies You Have Had in the last five years and date

EEG _____
Psych evaluation _____
MRI _____
ECG/EKG _____
CT scan _____
X-ray _____
Mammogram _____
DEXA/bone density _____

PERSONAL MEDICAL HISTORY (circle any history of these health issues)

TUBERCULOSIS	ARTHRITIS	MENSTRUAL DYSFUNCTION	DIZZINESS / FAINTING
SCARLET FEVER	KIDNEY DISEASE	DIABETES	CLAUDICATION
RHEUMATIC FEVER	LIVER DISEASE	THYROID DISEASE	HEART ATTACK
VENEREAL DISEASE	GASTRO-INTESTINAL	FATIGUE	HEART MURMUR
EPILEPSY / SEIZURE	GENITO-URINARY	BRONCHITIS / EMPHYSEMA	CONGENITAL HEART DZ
MENTAL ILLNESS	SEXUAL DYSFUNCTION	ASTHMA	CONGESTIVE HEART FAIL
CANCER	ANEMIA	ALLERGIES / HAY FEVER	HIGH BLOOD PRESSURE
GOUT	HYPERLIPIDEMIA	SHORTNESS OF BREATH	ARRHYTHMIA
ULCER	LYME DISEASE	ANXIETY	MS
ORTHOPNEA	PARKINSON	STROKE / TIA'S	

Have you ever been diagnosed with a mental illness? If yes please explain what illness and if you are currently being treated for it.

_____

SOCIAL HISTORY:

Do you currently use alcohol, marijuana, or other recreational drugs? If yes, please explain.

_____

FEMALES ONLY: I am NOT currently pregnant/breastfeeding or suspect that I am pregnant/breastfeeding.

_____
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MEDICATION LOG:

Allergies Drug/Food:_____

Medications: What medications are you taking now? Include non-prescription drugs?

	Medication Name	**Date started**	**Date Stopped**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

I have provided to the best of my ability, Independent Wellness Center and their Doctors with all medical records from all doctors from the previous 12 months.

_____
INITIALS

I acknowledge that the above information is true and correct to the best of my knowledge. I acknowledge that if there are any statements that may be false or need changing that I will inform Independent Wellness Center and make the correction.

_____
Signature Date

_____
Print Name Date of Birth Age

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Potential Risks and Benefits of Medicinal Marijuana from the Physician's View

Potential Risks:
***Potential for abuse**
***Sedation**
***Blood shot eyes**
***Coughing**
***Increased appetite**
***Lowers blood pressure**
***Bronchitis**
***Temporary mental confusion**
***Panic reactions**
***Hallucinations**
***Marijuana has the risks of contaminates such as, bacteria, fungi, molds, pesticides, herbicides, insects, fungicides**

Potential Benefits:
***Anti-inflammatory**
***Pain reduction**
***Anti-nausea**

Symptoms of Withdrawal:
***Nausea, vomiting, cough, depression, irritability, insomnia, sleep disturbances, fatigue, appetite loss**

Independent Wellness Center is not a dispensary.

I have read the above information and fully understand the RISKS AND BENEFITS of Medicinal Marijuana.

_____

Signature Date

_____

Print Name Date of Birth Age

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PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly, or indirectly.
- Obtain Payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Independent Wellness Center of our Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact Independent Wellness Center to obtain a current copy of this notice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand Independent Wellness Center is not required to agree to my requested restrictions, but if Independent Wellness Center does agree then they are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that Independent Wellness Center has taken action relying on this consent.

I acknowledge that I have read and understand all of the foregoing information. Please initial below.

_____
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PATIENT CONSENT and RELEASE OF LIABILITY FORM

I understand that a licensed physician recommendation that I may benefit from the use of medical marijuana does not guarantee that its use will help my qualifying condition. I release Independent Wellness Center and all affiliates (physicians, staff members, officers, investors, etc.) from all liability resulting in my use, possession, or the denial of my application for medical marijuana for any reason.

I also understand that any treatment or advice given to me as a patient is not mutually exclusive from any treatment or advice that I may receive now, in the future, or from another licensed health care provider.

I understand that I am currently under "self care." The physicians at Independent Wellness Center are in no way establishing themselves as my primary care physician, unless stated otherwise.

I agree to notify the physician on staff if I have been prescribed or am taking any supplements, herbs, or prescription medication for the condition, have ever had suicidal thoughts or symptoms, been diagnosed with a mental illness, or experience psychosis.

I acknowledge that while I may lawfully purchase, possess and use medical marijuana under state law, it is lawful only if done in strict compliance with the requirements of the State Medical Marijuana Act, Arizona Revised Statutes Title 36, Chapter 28.1, and Arizona Administrative Code Title 9, Chapter 17. Any failure to comply with the Act may result in the revocation of the registry identification card or registration certificate issued by the Arizona Department of Health Services, and possible arrest, prosecution, imprisonment and fines for violation of state drug laws. I have read and reviewed the Arizona Department of Health Services website at www.azdhs.gov/medical marijuana and I understand all rules and regulations involved with the program.

I acknowledge that I have read and understand all of foregoing information and I also understand the ultimate responsibility for my health is my own.

_____
_____
PRINT NAME **DATE**

_____

_____
SIGNATURE **DATE**

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