RADIANTLY
HEALTHY

Medical Marijuana New Patient Packet

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PLEASE COMPLETE THE FOLLOWING FORM.

SAVE THIS FORM TO YOUR COMPUTER OR DEVICE AND EMAIL TO NEWPATIENT@RH-MD.COM.
YOU MAY ALSO PRINT THE FORM, FILL IT OUT AND BRING IT INTO OUR OFFICE.

GENERAL INFORMATION

Name: ____
First *Middle* *Last*

Date of Birth: ______________________________________ **Gender:** ☐ **Male** ☐ **Female**

Employer: ____

Job Title: ____

Primary Address: ____
House Number and Street *Apt. No.*

____
City *State* *Zip*

Alternate Address: ____
House Number and Street *Apt. No.*

Preferred Contact Method ☐

Home Phone: ______________________ ☐ **Work Phone:** ______________________ ☐

Cell Phone: ______________________ ☐ **Fax Number:** ______________________ ☐

Email: ____ ☐

OK to Receive Text Messages About Appts etc? ☐

Emergency Contact: **Name:** ______________________ **Phone Number:** ______________________

Address: ____

____

Primary Care Physician Name: ____

Phone Number: ______________________ **Fax:** ______________________

Referred by: ☐ **Website** ☐ **Magazine Article** ☐ **Friend/Family** ______________________
☐ **Natural Awakenings** ☐ **Space Coast Living** ☐ **Other Doctor** ______________________

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Health Goals

What would be your top 3 things you want to achieve with our partnership in your health and wellness journey?

1. ______________________________

2. ______________________________

3. ______________________________

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MSQ - Medical Symptom/Toxicity Questionnaire

NAME:________________________________ DATE: ____________________

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If related to previous questionnaire, please record your symptoms for past 48 hours.

POINT SCALE
0 = Never of almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have it, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACT

___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching or passing gas
___ Heartburn
___ Intestinal/stomach pain

TOTAL ____

EARS

___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss

TOTAL ____

EMOTIONS

___ Mood Swings
___ Anxiety, irritability, aggressiveness
___ Depression

TOTAL ____

ENERGY/ACTIVITY

___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness

TOTAL ____

EYES

HEAD

___Headaches
___Faintness
___Dizziness
___Insomnia

TOTAL ____

HEART

___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___Chest pain

TOTAL ____

JOINT/MUSCLES

___ Pain or aches in joints
___ Arthritis
___ Stiffness, limitation of movement
___Pain or aches in muscles
___Feeling of weakness or tiredness

TOTAL ____

LUNGS

___ Chest congestion
___ Asthma, bronchitis
___Shortness of breath
___Difficulty breathing

TOTAL ____

MIND

___ Poor memory
___Confusion, poor comprehension

MOUTH/THROAT

___Chronic coughing
___Gagging: frequent need to clear throat
___ Sore throat; hoarseness; loss of voice
___ Swollen/discolored tongue, gum, lips

TOTAL ____

NOSE

___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___Excessive mucus formation

TOTAL ____

SKIN

___ Acne
___ Hives, rashes or dry skin
___ Hair loss
___Flushing or hotflashes
___Excessive sweating

TOTAL ____

WEIGHT

___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___Compulsive eating
___Water retention
___Underweight

___ Watery or itchy eyes
___ Swollen, reddened, sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel visions (does not include near or far-sightedness)

*TOTAL*_____

___Poor concentration
___Poor physical coordination
___Difficulty in making decisions
___Stuttering or stammering
___Slurred speech
___Learning disabilities

TOTAL ____

TOTAL ____

OTHER

___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge

TOTAL ____

GRAND TOTAL_______ Add individual scores and total each group. Add each group scores and give a grand total.

KEY - Optimal is less than 10   Mild Toxicity: 10-50   Moderate Toxicity: 50-100   Severe Toxicity: 100+

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SMOKING

Do you smoke currently? ☐Yes ☐No Packs per day: _______ Number of years: _______

What type? ☐Cigarettes ☐Smokeless ☐Pipe ☐Cigar ☐E-Cig

Have you attempted to quite? ☐ Yes ☐ No

If yes, using what methods? ____

If you smoked previously: Packs per day:_______ Number of years: _______

Are you regularly exposed to second-hand smoke? ☐ Yes ☐ No

ALCOHOL

How many alcoholic beverages do you drink in a week? *(1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)*

☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10 ☐ None

Previous alcohol intake? ☐Yes (☐Mild ☐Moderate ☐High) ☐None

Have you ever had a problem with alcohol? ☐Yes ☐ No

If yes, when? ____

Explain the problem: ____

Have you ever thought about getting help to control or stop your drinking? ☐Yes ☐No

OTHER SUBSTANCES

Are you currently using any recreational drugs? ☐ Yes ☐ No

If yes, type: ____

Have you ever used IV or inhaled recreational drugs? ☐ Yes ☐ No

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Medications/Supplements

Current medications (include prescription and over-the-counter)

Medication	Dosage	Start Date (mc/yr)	Reason for Use

Nutritional supplements (vitamins/minerals/herbs etc.)

Name and Brand	Dosage	Start Date (mc/yr)	Reason for Use

Have medications or supplements ever caused unusual side effects or problems? ☐ Yes ☐ No

If yes, describe: ______________________________

Allergies:

Medication	Year	Reaction

MEDICAL HISTORY: ILLNESSES/CONDITIONS

Check YES = a condition you currently have, CHECK PAST = a condition you've had in the past

Gastrointestinal	Yes	Past
Irritable bowel syndrome		
GERD (reflux)		
Crohn's disease/ulcerative colitis		
Peptic ulcer disease		
Celiac disease		
Other:		
Respiratory		
Bronchitis		
Asthma		
Emphysema		
Pneumonia		
Sinusitis		
Sleep apnea		
Other:		
Urinary/Genital		
Kidney stones		
Gout		
Interstitial cystitis		
Frequent yeast infections		
Frequent urinary tract infections		
Sexual dysfunction		
Sexually transmitted diseases		
Other:		
Endocrine/Metabolic		
Diabetes		
Hypothyroidism (low thyroid)		
Hyperthyroidism (overactive thyroid)		
Infertility		
Metabolic syndrome/Insulin resistance		
Eating disorder		
Hypoglycemia		
Other:		
Inflammatory/Immune		
Rheumatoid arthritis		
Chronic fatigue syndrome		
Food allergies		
Environmental allergies		
Multiple chemical sensitivities		
Autoimmune disease		
Immune deficiency		
Mononucleosis		
Hepatitis		
Other:		

Musculoskeletal	Yes	Past
Fibromyalgia		
Osteoarthritis		
Chronic pain		
Other:		
Skin		
Eczema		
Psoriasis		
Acne		
Skin cancer		
Other:		
Cardiovascular		
Angina		
Heart attack		
Heart failure		
Hypertension (high blood pressure)		
Stroke		
High blood fats (cholesterol, triglycerides)		
Rheumatic fever		
Arythmia (irregular heart rate)		
Murmur		
Mitral valve prolapse		
Other:		
Neurologic/Emotional		
Epilepsy/Seizures		
ADD/ADHD		
Heartaches		
Migraines		
Depression		
Anxiety		
Autism		
Multiple sclerosis		
Parkinson's disease		
Dementia		
Other:		
Cancer		
Lung		
Breast		
Colon		
Prostate		
Skin		
Other:		

MEDICAL HISTORY (cont.)

Diagnostic Studies	Date	Comments
Bone density		
CT Scan		
Colonoscopy		
Cardiac stress test		
EKG		
MRI		
Upper endoscopy		
Upper GI series		
Chest X-ray		
Barium enema		
Other:		
Injuries		
Broken bone(s)		
Back injury		
Neck injury		
Head injury		
Other:		
Surgeries		
Appendectomy		
Dental		
Gallbladder		
Hernia		
Tonsillectomy		
Joint replacement		
Heart surgery		
Other:		
Hospitalization	**Date**	**Reason**

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Diet, Nutrition, and Lifestyle Journal - 3 Day

Patient Name:______________________________ Date ____________________

Food Plan Type: ____

DAY 1

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		________P________F________C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack Time		________P________F________C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch Time		________P________F________C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack Time		________P________F________C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner Time		________P________F________C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack Time		________P________F________C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

P: Proteins F: Fats C: Carbohydrates R: Red; O: Orange; Y: Yellow; G: Green; B/P/BL: Blue/Purple/Black W/T/BR: White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
SLEEP Quantity:__________(hours) Quality: ☐Poor ☐Fair ☐Good RELAXATION ☐ Yes ☐ No Type/amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual

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Diet, Nutrition, and Lifestyle Journal - 3 Day

Patient Name:______________________________ Date ______________________

Food Plan Type: ____

DAY 2

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		________P________F________C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack Time		________P________F________C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch Time		________P________F________C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack Time		________P________F________C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner Time		________P________F________C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack Time		________P________F________C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

P: Proteins F: Fats C: Carbohydrates R: Red; O: Orange; Y: Yellow; G: Green; B/P/BL: Blue/Purple/Black W/T/BR: White/Tan/Brown

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Mental	Emotional	Spiritual

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Diet, Nutrition, and Lifestyle Journal - 3 Day

Patient Name:________________________________ Date ________________

Food Plan Type: ____

DAY 3

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		______P______F______C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack Time		______P______F______C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch Time		______P______F______C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
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Bed Time		

P: Proteins F: Fats C: Carbohydrates R: Red; O: Orange; Y: Yellow; G: Green; B/P/BL: Blue/Purple/Black W/T/BR: White/Tan/Brown

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Mental	Emotional	Spiritual

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