NEW CLIENT HEALTH HISTORY

Welcome To Cannabis Care Team of Kansas City. Thank You For Choosing Us.

Name: _______________________________ Date of Birth: _________ Age: _______ Today's date:__________

WHAT ARE YOUR HEALTH AND HEALING GOALS? WHAT ARE YOUR GOALS FOR THIS VISIT?

____

____

PLEASE LIST YOUR CURRENT HEALTH CONCERN(S):

____

____

FOR YOUR MOST PRESSING HEALTH CONCERN, PLEASE DESCRIBE THE FOLLOWING: What are the symptoms?

____

____

What makes it better, and what makes it worse? Does it interfere with your ability to function? Please describe.

____

____

When and how did this condition start?

____

____

What types of examinations have you had (doctors seen, tests performed, etc.)?

____

What treatments have you tried and how well have they worked?

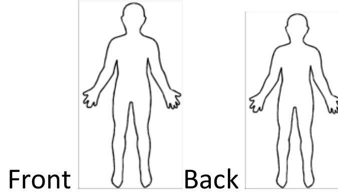
____

____

PAIN PATTERNS MAP

On the figures provided, 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 or Tingling= N N N N N



CANNABIS HISTORY Are you currently using cannabis? YES NO (If no, please skip to next section).

How? Please circle: pipe, joint, vaporizer, pen, tincture, edible, tea, topical, concentrates, other:_________________

How much? (e.g. 20mg CBD 3x/day, or 2 puffs 2x/day, or 1⁄4 oz/week) ______________________________________

Which strains work well, which don't? ____

How does cannabis help you? ____
____

Have you had any negative effects from cannabis? YES NO If yes, please describe:_______________________
____

PLEASE LIST YOUR CURRENT MEDICINES, SUPPLEMENTS, HERBS (w/ dosage):

____
____
____
____

PLEASE LIST ANY ALLERGIES (medications, food or environmental & your reactions):

____
____

DO YOU CURRENTLY HAVE A PRIMARY CARE PROVIDER? YES NO Name & Town / Practice____

What other medical providers are involved in your care? ____

MEDICAL HISTORY Please list any other major health problems, hospitalizations, and surgeries that you have had and when:
____
____
____
____ Please list any traumas you have experienced (abuse as a child, abusive relationships, sexual assault, military combat, fires, accidents, falls, head injuries, loss of loved ones, etc.):
____
____

FAMILY MEDICAL HISTORY Please list any significant health problems in your family members:
Mother____ Father____
Siblings____
Grandparents___________________________________ Other____

LIFESTYLE AND SOCIAL LIFE:

With Whom do you live?____

Do you feel safe at home? YES NO

Are you? Employed____ Unemployed____ Disabled____ Student____ Other______________________________

What do you do for work? ____

What do you do for fun and relaxation? ____
____

How much exercise do you get per week & what kind? ____
____

How many hours of sleep do you get each night? _________ Do you feel rested in the morning?_________________

How many servings do you drink per day? water_____ caffeinated beverages_____ alcohol (per week)______

What else do you drink and how much?____

How would you describe your diet?____

What did you eat yesterday?____
____

Tobacco (type, how much & how long)? ____

Have you had any recent major life changes?____

OTHER SYMPTOMS (Please circle any that you've experienced in the last 2 weeks):

GENERAL: Persistent Fatigue; Weakness; Fever/chills; Night sweats; Dizzy; Fainting; Weight loss/gain; Swollen glands; Feel like you've aged prematurely.

HEAD: Headaches; Eye pain; Trouble seeing; Trouble hearing; Stuffed nose; Tooth pain; Sore throat.

BREATHING: Cough; Excess phlegm; Bloody phlegm; Shortness of breath; Wheezing.

HEART & CIRCULATION: Chest pains; Swollen ankles; Trouble breathing when laying down; Trouble walking upstairs; Legs cramp after walking; Heart races or skips beats.

DIGESTIVE: Heartburn or reflux; Belly pain; Poor appetite; Nausea; Vomiting; Constipation; Diarrhea; Blood in vomit or stools; Black or tarry stools; Excess belching or passing gas; Rectal pain.

URINARY: Pain or burning with urination; Frequent urination; Leaking; Blood in urine; Decreased stream.

MUSCULOSKELETAL: Back pain; Painful muscles or tendons; Painful joints; Swollen joints; Morning stiffness; Muscle cramps; rib pain. Pains that come and go or move around w/out a clear reason.

NEUROLOGICAL: Radiating pain; Tingling; Numbness; Weakness; Blackouts; Tremors; Seizures; Trouble with balance, coordination, memory, attention, concentration, or the ability to process numbers.

MENTAL HEALTH: Persistent sadness; Worry; Anxiety; Guilt; Fear; Paranoia; Over-energized; Unprovoked mood swings; Panic attacks; Irritability; Flashbacks; Under-eating; Overeating; Thinking about harming myself / another. OTHER: Can't tolerate heat / cold; Excessive sweating; Nipple leaking; Change in appetite / thirst; Rash; Skin changes; Changed libido; Trouble or pain with sex.

FOR WOMEN: Irregular bleeding; Problems with periods; Lumps in breasts; Vaginal dryness; Hot flashes.

FOR MEN: Erection problems; Lumps or pain in testicles.

Have you been bitten by a black legged (deer) tick? YES NO

If yes, did you get a circular rash in the area of the bite? YES NO

Have you experienced a flu-like illness in the summer or fall from which you never fully recovered? YES NO

CLIENT CONSENT

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 CCTKC 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 Missouri 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.

I have been truthful with the nurse concerning my symptoms and condition. I will not to engage in hazardous activities while under the influence of marijuana. I understand this consultation is for educational purposes only and I will not make any action on any information provided without the consent of my physician.

____ ________________

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

CANCELLATION/NO SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another client from getting much needed education.. Conversely, the situation may arise when another client fails to cancel and we were unable to schedule you for a visit, due to a full schedule.

Cancellations: It is our policy that all appointments must be cancelled at least 48 hours in advance of the visit. If you reschedule and late cancel a second time, prepayment for your visit will be required. All patients will have the opportunity to show proof of an "urgent" reason as to why they were unable to make their scheduled appointment.

No Shows: A non-refundable $25 deposit is required at the time of booking. If you "no show" you will forfeit the non-refundable $25 deposit. All patients will have the opportunity to show proof of an "urgent" reason as to why they were unable to make their scheduled appointment. Upon doing so, the client will be reimbursed the charges incurred for not showing up for their scheduled appointment.

Scheduled Appointments: We understand that delays can happen, however, we must try to keep the other clients on time. If you are 15 minutes past your scheduled time, your educator may not be able to complete a full visit, or we will do our best to accommodate you and fit you into the schedule later in the day.

Payment: Full payment is required at the time of the appointment.

Confirmation Policy: You will receive an email or text message 3 days prior to your appointment that will ask you to confirm your appointment electronically. If your appointment has not been confirmed electronically, you will receive a phone call from our team asking you to call our office to confirm your appointment. If you DO NOT call our office back by the time requested to confirm your appointment, your appointment will be cancelled. When the appointment is cancelled, you will receive an additional call from our office confirming that your appointment has been cancelled.

I, ____do hereby acknowledge receipt of CCTKC's Cancellation/No Show policy.

Date:_______________________________

Privacy Policy

Commitment to Privacy

The appropriate collection, use and disclosure of clients' personal health information is fundamental to our day-to-day operations. Protecting the privacy and confidentiality of our client's personal information is important to the providers and staff at CCTKC. We strive to provide our clients with excellent service. Every member of CCTKC must abide by our commitment to privacy in the handling of personal information. Our Privacy Policy attests to our commitment to privacy and demonstrates the ways we ensure that patient privacy is protected. Our Privacy Policy applies to the personal health information of all our clients that is in our possession and control.

What is Personal Health Information? Personal health information means identifying information about an individual relating to their physical or mental health (including medical history), the providing of health care to the individual, payments or eligibility for health care, organ and tissue donation and health number.

The 10 Principles of Privacy

Our Privacy Policy reflects our compliance with fair information practices, applicable laws and standards of practice.

1. Accountability

We take our commitment to securing patient privacy very seriously. Each physician and employee associated with the Practice is responsible for the personal information under his/her control. Our employees are informed about the importance of privacy and receive information periodically to update them about our Privacy Policy and related issues.

2. Identifying Purposes: Why We Collect Information

We ask you for information to establish a relationship and serve your medical needs. We obtain most of our information about you directly from you, or from other health practitioners whom you have seen and authorized to disclose to us. You are entitled to know how we use your Information. We will limit the information we collect to what we need for those purposes, and we will use it only for those purposes. We will obtain your consent if we wish to use your information for any other purpose.

3. Consent

You have the right to determine how your personal health information is used and disclosed. For most health care purposes, your consent is implied as a result of your consent to treatment, however, in all circumstances express consent must be written. Your written consent will be documented in your medical records.. It is understood that the consent directive applies only to the PHI which the patient has already provided, and not to PHI which the patient might provide in the future: PHIPA permits certain collections, uses, and disclosures of the PHI, despite the consent directive; healthcare providers may override the consent directive in certain circumstances, such as emergencies; and the consent directive may result in delays in receiving health care, reduced quality of care due to healthcare provider's lacking complete information about the patient, and healthcare provider's refusal to offer non-emergency care.

4. Limiting Collection We collect information by fair and lawful means and collect only that information which may be necessary for purposes related to the provision of your medical care.

5. Limiting Use, Disclosure and Retention The information we request from you is used for the purposes defined. We will seek your consent before using the information for purposes beyond the scope of the posted Privacy Statement. Under no circumstances do we sell patient lists or other personal information to third parties.

6. Accuracy

We endeavour to ensure that all decisions involving your personal information are based upon accurate and timely information. While we will do our best to base our decisions on accurate information, we rely on you to disclose all material information and to inform us of any relevant changes.

7. Safeguards: Protecting Your Information

We protect your information with appropriate safeguards and security measures. CCTKC maintains personal information in electronic files. Access to personal information will be authorized only for the employees associated with CCTKC, and other agents who require access in the performance of their duties, and to those otherwise authorized by law. We will give them only the information necessary to perform the services for which they are engaged, and will require that they not store, use or disclose the information for purposes other than to carry out those services. Our computer systems are password-secured and constructed in such a way that only authorized individuals can access secure systems and databases. If you send us an e-mail message that includes personal information, such as your name included in the "address", we will use that information to respond to your inquiry. Please remember that your e-mail is not necessarily secure against interception. If your communication is very sensitive, you should not send it electronically unless your e-mail is encrypted or your browser indicates that the access is secure.

8. Openness: Keeping You Informed CCTKC has prepared this plain-language privacy policy to keep you informed. If you have any additional questions or concerns about privacy, we invite you to contact us by phone and we will address your concerns to the best of our ability.

9. Access and Correction

With limited exceptions, we will give you access to the information we retain about you within a reasonable time, upon presentation of a written request and satisfactory identification. We may charge you a fee for this service and if so, we will give you notice in advance of processing your request. If you find errors of fact in your personal health information, please notify us as soon as possible and we will make

the appropriate corrections. We are not required to correct information relating to nursing observations or opinions made in good faith. You have a right to append a short statement of disagreement to your record if we refuse to make a requested change. If we deny your request for access to your personal information, we will advise you in writing of the reason for the refusal and you may then challenge our decision.

10. Challenging Compliance

We encourage you to contact us with any questions or concerns you might have about your privacy or our privacy policy. We will investigate and respond to your concerns about any aspect of our handling of your information. In most cases, the issue can be resolved simply by telling us about it and discussing it.

Acknowledgement of Privacy Practices

I,____, do hereby acknowledge receipt of a copy of the Notice of Privacy Practices and Procedures from Integr8 Health, LLC

I authorize Integr8 Health, LLC to review and discuss my medical information with the following individual(s): (leaving blank will only permit us to speak with you directly).

Full Name:__________________________________ Relationship & Phone Number:___________________________

Full Name:__________________________________ Relationship & Phone Number:___________________________

____ ____

Signature of Individual Date:

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

____ ____

____ ____ Signature of Client or Client's Parent/Legal Guardian Date:

____ Legal Authority of Personal Representative