Alternative Medicine Outreach Program
Integrated Wellness Center &Preventive Medicine
455 W. Corey Court Roseburg, OR 97470

AMOP INTAKE FORM

Please complete the information below, so we can better serve you.

Date: ______________

Patient Name: ____
(LAST) (FIRST) (MI)

Mailing Address: ____

Physical Address: ____

City: ______________________ State: ______________ Zip: __________

Home Phone: ________________ Work Phone: ______________________

Cell Phone: _________________ ODL#/ ID#: ______________________

Date of birth: ______________ Social Security Number: ______________

Email Address: ____________________________ Male/ Female__________

Current Medicines: ____

Have you been seen here before? _____yes _____no. If yes, has your health

Condition changed since the last time you were in here? _____yes _____no.

If YES, please explain: ____

Are you on probation or parole? ____yes _____no- if so, for what? ______________

How did you hear about us? ____

Would you like to receive an AMOP Newsletter mailing list? _____yes _____no

Patient has read and completed application truthfully and understands that appointment CANELLATIONS need to be 24 HOUR business day prior to appointment or fees will be charged.

Signature ______________________________ Date ______________

Patient received HIPPA information (patient initials) ____________________

Patient received Cannabis (marijuana) Drug information ________________

Station #3 initials ____________

Appointment Date/ Time ____________________2004 @______________

Alternative Medicine Outreach Program (AMOP)

455 West Corey Court, Roseburg, Oregon 97470

ELIGIBILITY QUESTIONNAIRE

For compliance with the Oregon medical Marijuana Act

Unauthorized release of information contained in this document is in violation of doctor patient confidentiality.

Appointment date:________/________/_______ Visit Site: ____

Referred by: ________________________________ and/or visited web site ❐ *check if yes*

Identifying Data

Patient's Name ____
(First) (Middle) (Last)

Street Address: ____ Apt. Number:________

City: ____ State:___________ Zip Code___________ - _____

Mailing Address ____

Date of Birth________/________/_______ Oregon Drivers Licence / ID# ____________________________

Home Phone: (______) _________-________________ Work Phone (______) _________-____________

FAX: (_____) ______-____________ Pager: (____) ______-___________Cell:: (____) ______-__________

Best time to contact: ❐ Morning ❐ Afternoon ❐ Evening ❐ Any ❐ OK at work

	Yes	No
If you qualify for OMMA, do you intend to grow your own Medicine?	_______	________
Will need help finding a care giver?	_______	________
Would you like to volunteer time, money, medicine or crafts to this	_______	________
organization now or in the future?	_______	________

I the undersigned, hereby state that the information contained in this questionnaire is true to the best of my knowledge.

Patient Signature ____ Date:________________

Military Information

Have you ever served in the Military? ☐ No ☐ Yes
If yes please complete the following:

Branch of Service: ☐ Army ☐ Air Force ☐ Marines ☐ Navy ☐ Coast Guard
☐ National Guard ☐ Other ______________

Service in Vietnam? ☐ Yes ☐ No Highest Rank: ________________

Length of Service: _________________

Discharge: ☐ Honorable ☐ Dishonorable ☐ Medical ☐ General

If other please explain: ____

Family Medical History

Mother: ☐ Alive ☐ Deceased Age : _______

Father: ☐ Alive ☐ Deceased Age : _______

Medical history includes:

	Mother	**Father**
Cancer	☐	☐
Hypertension	☐	☐
Heart Disease	☐	☐
Diabetes	☐	☐
Mental Disorders	☐	☐
Alcohol Abuse	☐	☐
Other Problems	☐	☐

Ages of siblings and your children if any:

____

____

____

Past Medical History

Allergies:

Medications: ______________________________

Food: ______________________________

Other: ______________________________

Trauma or Injury

Have you been injured in a traffic accident? ☐ Yes ☐ No Date: ___-___-___

Explain: ______________________________

____

Have you had any fractures, dislocations, breaks or head injury? ☐Yes ☐ No

Explain: ______________________________

List any past illnesses, injuries, and/or surgeries: ______________________________

____

____

Present Illness

List in order of seriousness, the diseases, conditions, or symptoms you use Medical Marijuana for:

Primary Illness: ____________________ Date of injury or onset: ____________

course (include: surgeries, medications, prescribed treatments and results, alternative care, etc.) **Be as complete and accurate as possible**

____

____

____

____

Secondary Illness: ____________________ Date of injury or onset: ___________

Course (include: surgeries, medications, prescribed treatments and results, alternative care, etc.) **Be as complete and accurate as possible**

____

____

____

____

List any other medical reasons for which you use cannabis:

____

____

____

Cannabis Use Pattern

Cannabis type preferred (such as bud, oil, hashish etc.): ____________________

At what age and how did you discover that cannabis helped your medical symptoms?____

____

Which comes first when you medicate? ☐ Mental Changes ☐ Physical Changes

How long does it take to relieve your ailment? ________________________________

Preferred method of cannabis intake: ☐ Oral ☐ Joint ☐ Pipe ☐ Water Pipe
If other please explain: ____

How often do you use cannabis? ____

How much cannabis do you use per week? __________________________________

Has your cannabis consumption changed in the past 6 months? ☐ Yes ☐ No
If changed, to what do you attribute the change?______________________________

Would you use more if it were easier to obtain? ☐ Yes ☐ No
If yes, How much more? ☐ 25% ☐ 50% ☐ 75% ☐ 100% Other: _________

Overall, how does cannabis affect your condition/symptoms?_______________

____

____

____

Have you ever discontinued your cannabis and found a worsening or return of symptoms, If yes please explain:_______________________________

____

____

____

Have you ever used Marinol (synthetic THC): ☐ Yes ☐ No
If Yes, was it prescribed? ☐ Yes ☐ No
What symptoms was it used for?_______________________________
Results:_______________________________________

____

____

Side Effects

How do the unwanted side effects of cannabis if any compare to those of your usual prescription drugs?_______________________________________

____

____

Would you be interested in taking part in a cannabis related research study?
☐ Yes ☐ No If yes, We will contact you.

Legality

Are you on probation or parole? ☐ Yes ☐ No
If yes, explain: _______________________________________

____

____

Do you have a pending cannabis case? ☐ Yes ☐ No
If yes, explain: _______________________________________

____

____

Other medications and drugs

Prescribed and over the counter medicines and herbs used to treat **condition(s) for which cannabis is used.** List and indicate all medications that you have discontinued, list reasons for discontinuing. Please mark all that apply, be as complete and accurate as possible.

Examples for discontinuing

- Nausea
- Lethargy
- Itching
- Tremor
- Tiredness
- Sleeplessness
- Irritability
- Anorexia
- Weakness
- Anxiety
- Indigestion
- Depression
- Constipation
- Sweating
- Dizziness
- Dry mouth
- Social Withdrawal
- Meanness

Schedule II	Presently use	$ Month	Reason for discontinuing use:
Oxycontin			
Oxycodone			
Percodan			
Ritalin			
Amphetamine			
Percodan			
Percocet			

Schedule III	Presently use	$ Month	Reason for discontinuing use:
Xanax			
Valium			
Ambien			
Tylenol /codeine			
Vicodin			
Soma			
Ativan			
Trazadone			
Baclofen			
Elavil			
Imipramine			

SSRI	Presently use	$ Month	Reason for discontinuing use:
Prozac			
Paxil			
Effexor			

NSAID	Presently use	$ Month	Reason for discontinuing use:
Aspirin			
Ibuprofen			
Aceteminophin			
Alleve			

Other	Presently use	$ Month	Reason for discontinuing use: