



MEDICAL QUESTIONNAIRE

Date _____

Please answer these questions as completely as you can.

We realize this form is long, but the information is extremely valuable to us in providing the best possible care.

Patient name _____

Last

First

Middle

Phone _____ Date of birth _____

Patient's occupation _____

Emergency contact _____

Relationship to patient _____

Phone number/s _____

If you were referred, who told you about Michigan Holistic Health? (please circle)

Physician _____ Family/Friend _____

Compassion Club _____ Other _____

If you heard or saw advertising or a news story, please tell us where – all that apply.

Newspaper article Print ad TV ad Radio ad

Media interview Billboard Internet / website

Please check whether if you'd like a list of free/low cost clinics

YES NO

_____ Please initial to acknowledge that you have brought us all the records you can obtain from doctors who have cared for your qualifying condition.



AUTHORIZATION TO NOTIFY YOUR PRIMARY CARE PHYSICIAN.

Please check whether you'd like us to notify your primary care physician of your visit today.

NO

YES *I request and authorize Michigan Holistic Health to alert my primary care doctor that I have been recommended to apply to the Michigan Medical Marijuana Program by Michigan Holistic Health.*

PLEASE SIGN BELOW

Signature _____ Date _____

Your name: _____ Date of birth _____

IF YES, please fill out information below:

Primary physician name _____

City, state _____

Phone # _____
Area code

FAX # (if available) _____
Area code

To the primary care physician/practice: We are sending this notice as a courtesy to our mutual patient.

S/he was seen in our practice today and plans to apply to the Michigan Medical Marijuana Program for a registry card.

It is the professional opinion of our doctor that the applicant is suffering from the following debilitating medical condition:

The medical use of marijuana is likely to provide palliative or therapeutic benefits for the symptoms or effects of the patient's condition.

We have not prescribed marijuana, rather have affirmed the patient's condition on paperwork the patient plans to send to the state.

Please call with any questions: 855-420-8100.

THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT'S SIGNED

GENERAL MEDICAL HISTORY

List your current and past illnesses (such as diabetes, hypertension, etc.)
(Do NOT include eye conditions that you have previously listed.)

Condition	Month/year diagnosed
_____	_____
_____	_____
_____	_____
_____	_____

Please list all previous surgical procedures (not involving eyes) and their dates (if known):

Surgical Procedure	Month/year
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS:

Please list all medications that you are currently taking and their dosage (if known):

Medication	Dose	# of times per day	For how long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you taking aspirin or any other over-the-counter medicines? No ___ Yes ___

If yes, please list: _____

Do you have any known drug allergies? No ___ Yes ___

If yes, please list: _____

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING SYMPTOMS OR PROBLEMS?

	<u>NO</u>	<u>YES</u>		<u>NO</u>	<u>YES</u>
<u>General</u>			<u>Lungs/Breathing</u>		
Fever	___	___	Breathing difficulty	___	___
Unexplained weight loss	___	___	Asthma	___	___
Night sweats	___	___	Lung disease	___	___
<u>Ear, nose, or throat</u>			<u>Digestive System</u>		
ringing in ears	___	___	Diarrhea	___	___
Hearing Loss	___	___	Ulcer disease	___	___
Pain	___	___	Hepatitis	___	___
<u>Nervous System</u>			<u>Genitourinary</u>		
Headache	___	___	Kidney disease	___	___
Stroke	___	___	Urinary tract infection	___	___
Seizure/epilepsy	___	___	Urinary bleeding	___	___
Weakness, numbness, tingling	___	___	Altered menses	___	___
<u>Heart or circulatory problems</u>			<u>Blood</u>		
Heart attack or heart failure	___	___	Anemia (low blood count)	___	___
Irregular heart rhythm	___	___	Blood tumors/disease	___	___
Chest pain	___	___	Swollen glands	___	___
Pacemaker	___	___	Bleeding disorder	___	___
Hypertension	___	___	<u>Musculoskeletal</u>		
<u>Endocrine</u>			Joint pain/arthritis	___	___
Thyroid disease	___	___	Fractured bones	___	___
Diabetes	___	___	Pain with chewing	___	___
Hormonal disease	___	___	Scalp pain/tenderness	___	___
<u>Allergy/Immunology</u>			<u>Psychiatric</u>		
Environmental allergies	___	___	Depression	___	___
Iodine allergy	___	___	Mood swings	___	___
Contrast material (dye) allergy	___	___	Anxiety	___	___
Cat scratch or cat bite	___	___	Admission to hospital/ psychiatric illness	___	___
<u>Skin/breast</u>			<u>Other:</u>		
Masses/tumors	___	___	_____		
Rash	___	___	_____		
Discharge from breast	___	___			

COMMENTS: _____



“No marijuana-related legal action pending” Agreement

By signing below, I, _____, assert that
as of today, the ____ day of _____ in the year _____,

I have NO marijuana-related legal issues pending in the courts of any level of government.

Examples of pending marijuana-related legal issues include, but are not limited to: unresolved misdemeanor or felony criminal charges stemming from the growing, possessing or operating a vehicle under the influence of marijuana, probation violation hearings concerning testing positive for marijuana activity (medical or otherwise) and civil actions against employers or former employers concerning termination of employment relating to your status as a medical marijuana patient.

I understand that according to the Michigan Medical Marihuana Act’s affirmative defense outlined in MCL 333.76428(a)(1), a bona-fide patient-doctor relationship must be established by any defendant/patient who seeks to have his criminal charges successfully dismissed under the MMMA. I understand and agree that breaching this agreement will render null and void any bona-fide patient-doctor relationship that may have existed between myself and the physicians at Michigan Holistic Health, PLLC at the time of service.

I also further assert that any and all information I give pertaining to my “qualifying condition” as defined by the State of Michigan, is accurate and complete.

I further understand that should an applicable court refuse to dismiss a pending criminal charge as a result of the contents of this agreement, I will hold Michigan Holistic Health, PLLC harmless for the legal consequences associated with my potential sentence, incarceration, civil forfeiture, fines, restitution, court and attorney costs.

This agreement pertains to treatment and services provided by Michigan Holistic Health PLLC – a Michigan Corporation.

Signature of Patient _____ Date _____

Signature of Witness _____ Date _____

Michigan Holistic Health, PLLC



Physician Release from all Liability Form

Signing this form releases the physicians of Michigan Holistic Health from all liability for providing a state of Michigan medical marijuana “Physician’s Certification.” And by signing this form, you, the patient-applicant, are stating that you understand and agree with the following statements of fact:

1. The federal Food and Drug Administration approves all drugs prescribed by physicians. Medical Marijuana is not an FDA approved medication. Crude marijuana is not standardized regarding its purity, strength or dosage size.
2. Therefore, the physicians of Michigan Holistic Health cannot write a prescription for medical marijuana and has no control over the ingredients or the effects or the adverse risks of whatever medical cannabis you decide to consume and cannot in any way help or tell you how to acquire or grow it.
3. The physicians of Michigan Holistic Health may not be able to provide you with thoroughly researched conclusions regarding all the potential benefits and adverse risks of cannabis use for your particular qualifying medical condition. The scientific research on cannabis is incomplete and does not meet the high requirements for all other medicines approved by the FDA.
4. The physicians of Michigan Holistic Health cannot provide you with a regimen for the use of medical marijuana. You are solely responsible for administering medical marijuana as your condition warrants, as determined on the basis of your own judgment and are solely responsible for all the consequences.
5. The cultivation, possession and use of cannabis – even for medical purposes – remains a crime under federal law.
6. Medical marijuana is generally tolerated well by patients. Any side effects tend to be mild and temporary, usually lasting one week or less as patients adjust. Common side effects include irritated throat, dry mouth, elevated heart rate, mild time and space disorientation, mild euphoria, a general sense of well-being, and in some instances drowsiness and amotivation.

I, _____, agree not to make any legal claim or complaint, or commence any proceeding against Michigan Holistic Health & Assoc. in providing me with a “Physician’s Certification” as required by the Michigan Medical Marijuana Act. And I further agree not to make any legal claim or complaint or commence any proceeding against the same physician for my use use of crude medical marijuana. I release the same physician from any and all actions, causes of actions, claims, complaints and demands for damages, loss of injury whatsoever arising directly or indirectly as a result of my medical marijuana application to the state of Michigan or my use of medical marijuana. This release of liability is to be binding on my heirs, executors and assigns. I have read, understand and agree with all the statements in this form.

Signature of applicant

Date

Signature of witness

Date

****APPLICATION FORM****
for Registry Identification Card

PROOF OF MICHIGAN RESIDENCY IS REQUIRED

- For Applicants/Patients 18 years of age or older
- Please call our office if you have any questions
- Submit ALL documents in ONE envelope • We recommend the applicant/patient submit the application packet • Type or print legibly

NEW: I have never applied before or my registry ID card is expired **RENEWAL:** My current registry ID card is **not** expired

For Renewals: Check any Changes: Patient Address Change Caregiver Address Change Plant Possession
 Patient Adding or Changing to New Caregiver (List the new caregiver's information in Section B)
 Patient Name Change Caregiver Name Change (Documents required for name changes; see question #2 on page 2)

Section A: APPLICANT/PATIENT INFORMATION: (REQUIRED)

For Renewals: Current Card Registry ID Card Number: P _____ Male Female
Legal Name (First): _____ (MI): _____ (Last): _____
Social Security Number: _____ Date of Birth: _____
Mailing Address: _____ (if applicable) Apt/Lot # _____
City: _____ Zip: _____ Phone Number (with area code): _____
Alternate Phone Number (with area code): _____

****A patient who is 18 years of age or older is not required to designate a caregiver****

- ▶ To add or change to a new caregiver or retain your current caregiver, you **must** complete Section B and refer to questions #8-9 on page 2.
- ▶ Leave Section B blank **ONLY** if you are **NOT** designating a caregiver.

Section B: PRIMARY CAREGIVER INFORMATION: (IF APPLICABLE)

For Renewals: If already registered to this patient, Current Registry ID Card Number: C _____ Male Female
Legal Name (First): _____ (MI): _____ (Last): _____
Social Security Number: _____ Date of Birth: _____
Mailing Address: _____ (if applicable) Apt/Lot # _____
City: _____ Zip: _____ Phone Number (with area code): _____
Alternate Phone Number (with area code): _____

Plant possession will default to the Applicant/Patient if neither or both boxes are checked in Section C.

Section C: PERSON ALLOWED TO POSSESS PATIENT'S MARIHUANA PLANTS: (REQUIRED)

SELECT ONLY ONE: APPLICANT/PATIENT <----- **OR** -----> PRIMARY CAREGIVER

Michigan Medical Marihuana Registry APPLICATION FORM

To ensure this application is complete, the Applicant/Patient must answer **YES** to all of the applicable questions below:

1. Did you, the applicant/patient, answer all of the fields correctly and legibly in **Section A**?..... YES
2. **For renewals**, is a copy of documentation provided for a name change? (if applicable)
(I.e., marriage/divorce decree, legal name change document, valid MI driver license or Michigan ID, etc)..... YES
3. Are all of the fields for the caregiver answered correctly and legibly in **Section B** (if you, the patient, designated a caregiver)?..... (if applicable)
 YES
4. Is only one box checked in **Section C** for person who is allowed to possess the patient's Marihuana plants?..... YES
(if #5 is NO, #6 must be YES)
5. Did you, the applicant/patient, sign and date this application in **Section D** below?..... YES NO
6. **OR**, is a copy of a **Durable Power of Attorney for Health Care** or legal guardianship with signatory authority provided, if the applicant/patient is unable to sign this application?..... (if #6 is NO, #5 must be YES)
 YES NO
7. Is a valid, clear copy (front and back) of the applicant/patient's Michigan driver license or Michigan ID provided **OR** your **photo ID and Michigan voter registration** provided?..... YES
8. Is a valid, clear copy (front and back) of the caregiver's Michigan driver license or Michigan ID provided **OR** his/her **photo ID and Michigan voter registration** provided (if you, the applicant/patient, designated a caregiver in Section B)?..... (if applicable)
 YES
9. Is a copy of the **Caregiver Attestation**, correctly and legibly completed by the caregiver, provided (if you, the applicant/patient, designated a caregiver in Section B)?..... (if applicable)
 YES
10. Is the **Physician Certification** provided?..... YES
11. Is the \$100.00 Registration Fee included, payable to State of Michigan-MMMP?..... (if #11 is NO, #12 must be YES)
 YES NO
Enter the \$100.00 Check or Money Order # _____
12. **OR**, if you are eligible for the reduced fee, is the \$25.00 Registration Fee included, payable to State of Michigan-MMMP? (**Additional documents required-See #13**)..... (if #12 is NO, #11 must be YES)
 YES NO
Enter the \$25.00 Check or Money Order # _____ (if applicable)
13. Is the acceptable supporting documentation for the reduced fee included?..... YES
Examples of acceptable supporting documentation for the reduced fee are available at www.michigan.gov/mmp.
14. Check the program you, the applicant/patient, are currently enrolled in which qualifies you for the reduced fee:
 Full Medicaid Social Security Disability Supplemental Security Income (SSI)
15. Make a copy for your records and mail only one complete application, the check or money order, and all required documentation in one envelope to: **Michigan Medical Marihuana Registry Program • PO Box 30083 • Lansing, MI 48909**

Section D: APPLICANT/PATIENT SIGNATURE & DATE: (REQUIRED)

By signing below, I attest that the information I have entered on this application is true and accurate:

▶ Signature of Applicant/Patient: **X** _____ Date: _____

WHAT TO EXPECT AFTER YOU SUBMIT YOUR APPLICATION:

1. When your application is received by our office it will be approved or denied within 15 business days.
2. If this application is denied, the patient will receive a certified letter of explanation. You can then resubmit a copy of the application, with all required documents, for reconsideration up to 2 years from the date the fee is received.
3. If this application is approved, it will be processed in the date order received. The patient, and caregiver if designated, will be issued and sent a registry ID card to the mailing address provided on this application.
4. **If you have not received a denial letter, an approval letter, or some form of notification within six (6) weeks from the date the MMP receives your valid application, please contact our office at 517-373-0395 and select option #3. Please allow a full 6 weeks.**
5. After submitting this application, any changes to your record (address, caregiver, name, etc.), prior to your registry ID card's expiration, should be submitted on a Change Form with the required fee. We recommend not submitting a Change Form within 60 days of submitting your renewal application.