

Current medications: _____

What is the cause of your severe, chronic pain? Be as detailed as possible, including accidents, injuries, including dates.

How does your condition limit your quality of life (ie. sleep, work, relationships)? _____

What treatments have you sought for your condition? _____

What makes your condition worse? _____

What makes your condition better? _____

Surgical/Hospitalization History (dates and procedures): _____

Social History: Tobacco use: N Y Alcohol use: None Social Excessive

Do you suffer from any addictions? N Y Please specify: _____

Exercise: N Y ____ times per week

Card holders only: How has MMJ helped your condition(s) _____

Method of MMJ use (circle): smoke vape topical edible tincture

Name _____ Date _____

PATIENT CONSENT AND ACKNOWLEDGEMENT

Please initial each of the following:

_____ I am aware that the federal government has classified marijuana as a Schedule I substance, and as such prohibits its legal acquisition and possession; and that its use is strictly made available in Arizona for medicinal purposes only.

_____ I am aware that marijuana can cause significant impairment of judgment, coordination, and reflexes. I will not use marijuana when operating a motor vehicle or heavy machinery.

_____ I am aware that marijuana can also negatively affect decision making and judgment. I will not use marijuana when caring for children or other individuals under my care, supervision, or protection.

_____ I am aware of the potential side-effects of marijuana which include but are not limited to: depersonalization, amotivational syndrome, anxiety, panic attacks, exacerbation of schizophrenia, increased risk of lung infection, and hyperemesis (excessive vomiting) cannabinoid syndrome.

_____ I am aware that a medical marijuana card does not protect me from DUI, and if deemed impaired by a field officer I will be processed according state DUI laws.

_____ I am aware that a medical marijuana card does not protect me from termination by an employer if marijuana use is not consistent with that company's human resources guidelines.

_____ I am aware of the potential interactions with the following substances and drugs: alcohol, barbiturates, antidepressants, anti-anxiolytics, antipsychotics, blood thinners, blood pressure drugs, theophylline, and disulfiram, anti-histamines, and other recreational, prescription and non-prescription drugs.

_____ I am aware that marijuana may pose danger to fetuses while pregnant or to infants while breastfeeding. I am also aware that the use of marijuana while pregnant may result in a risk of being reported to the Department of Child Safety.

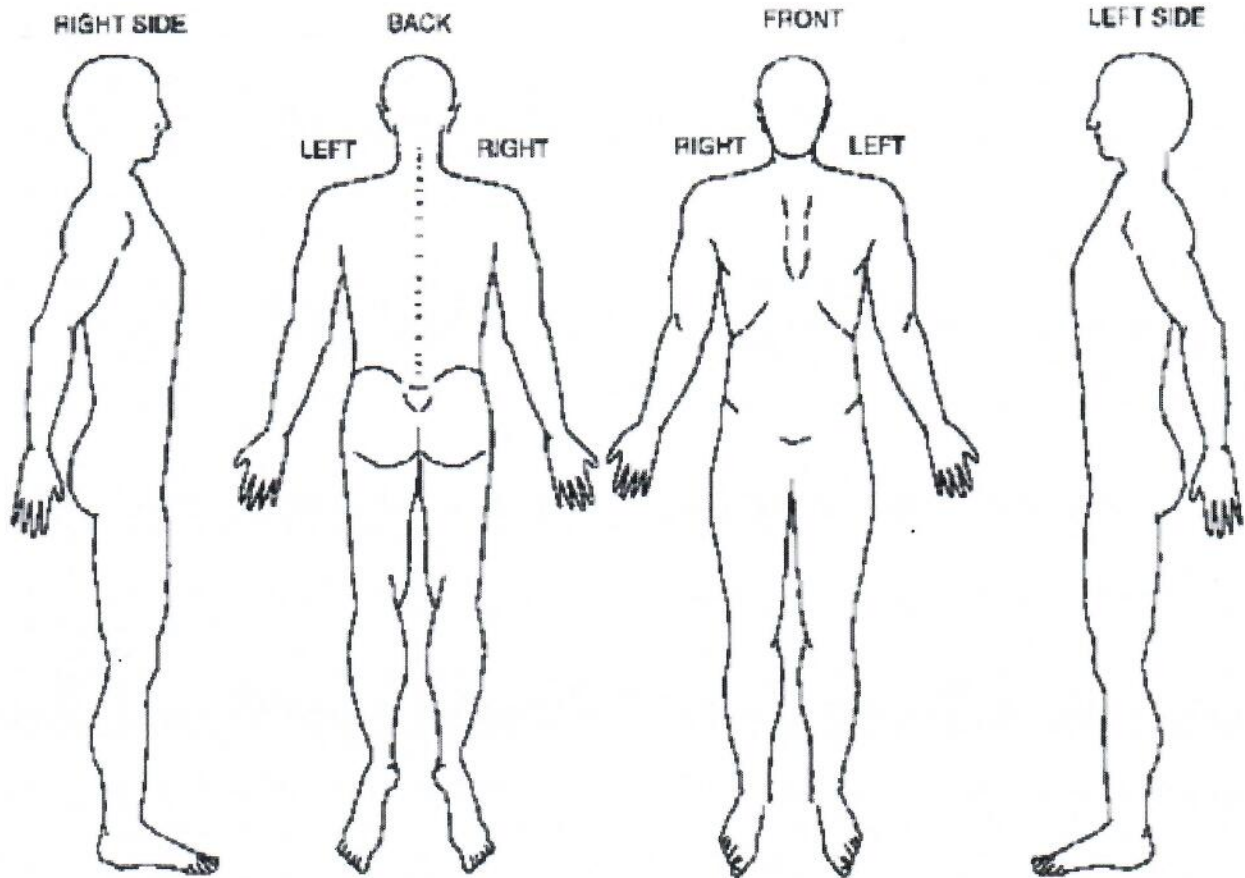
I _____ acknowledge that I have provided and will provide true and accurate information in this questionnaire packet and to the doctor. I have not misrepresented myself or my medical condition in any way in order to falsely obtain a medical marijuana card. I understand that it is my responsibility to comply with state and federal laws regarding the responsible and legal use of marijuana for medicinal purposes only. I understand that this visit is strictly for medical certification so that I may apply through the Arizona Department of Health Services to obtain a medical marijuana card. This visit in no way substitutes for medical advice nor is medical advice given pertaining to my health condition. I understand that beyond the certification obtained in this visit, the state of Arizona utilizes their own set of criteria on which they base their final decision whether or not to administer a medical marijuana card. Finally, I understand that there is no guarantee my application will be submitted prior to my card expiration and that last minute evaluations may result in card expiration.

Signed _____

Date _____

Pain Indication Chart

In the diagram below please mark with an 'X' all areas of pain you currently suffer from.-



Average pain range _____ to _____ out of 10.

Location: _____

Average pain range _____ to _____ out of 10.

Location: _____

Average pain range _____ to _____ out of 10.

Location: _____

NOTICE TO PATIENTS

**THE PATIENT FOR LIFE PROGRAM HAS
BEEN DISCONTINUED BY MEDMEN
CORPORATE. ANY GRIEVANCE YOU
MAY HAVE MUST BE TAKEN UP WITH
MEDMEN CORPORATE.**

Valley Certification and Wellness (VCW) and Level Up Dispensary are entirely separate entities. Any issues regarding VCW services or policies must be directed to the staff and management of VCW only. Level Up Dispensary can not resolve any issues related to our policies or services.

Patient signature _____



MARIJUANA PROGRAM PATIENT ATTESTATION

I, _____, attest that:

I will not divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant A.R.S. Title 36, Chapter 28.1 and that the information provided in the application is true and correct.

Signature

Date Signed