BURNS INTEGRATIVE WELLNESS CENTER

Burns Integrative Wellness Center

34406 N. 27th Drive Suite 114
Phoenix AZ 85085

Office: 623-252-0376
Fax: 623-399-1059

Please ensure the following information is accurate and legible as it will be used to submit your card application to the Health Department.

First & Last Name _____

Residential Address [No PO Box]

Street _____

City _____ Zip _____

Phone Number _____

Email [required by AzDHS] _____

Mailing Address

☐ Same as residential ☐ Alternate Address [fill in below]

Street _____

City _____ Zip _____

Y	N	
☐	☐	**Are You a Veteran?**
☐	☐	**Social Security Disability**
☐	☐	**AZ SNAP / EBT Program [Food Stamps]** To qualify for the program discount offered by the Health Department, you must provide a copy of your SNAP/EBT card [if it shows your name] or your Award Letter.
☐	☐	**Would you like to cultivate** To Qualify for cultivation, you must live more than 25 miles from an operating dispensary.

By signing below, I attest that the information I provided above is accurate, and agree to be responsible for any potential fees if I need to change the information with the Health Department.

Signature Patient _____ Patient Name [Printed] _____ Date _____

If needed, Signature of authroized representative _____ Representative Name [Printed] _____ Relationship to patient _____ Date _____

Authorized Facility Signature _____ Date _____

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Personal Information

Name _____ Age _____ Date of Birth _____
Height _____ Weight _____ Gender ☐ Male ☐ Female

Address _____
City _____ State _____ Zip _____

☐ Married
☐ Divorced
☐ Single
☐ Widow
Children _____

Home Phone _____
Cell Phone _____
Work Phone _____
Email Address _____

Spouse _____ Phone _____
Emergency Contact _____ Phone _____

Occupation _____ ☐ FT ☐ PT
Employer _____

☐ Y ☐ N Would you like to subscribe to out newsletter? [No more than 1-2 emails per month] Our newsletter includes health-related articles and healthy recipes.

☐ Y ☐ N Is it okay if we send SMS text appointment reminders to your mobile phone?

How Did You Learn About Our Office?

☐ Attorney ☐ Family ☐ Google ☐ Other _____
☐ Mailer ☐ Co-Worker ☐ Yelp ☐ Counselor / Therapist
☐ Friend ☐ Physician ☐ Facebook ☐ Instagram

If referred, by whom _____

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CERTIFIED BRAIN HEALTH COACH

PRECISION NUTRITION Pn CERTIFIED

Medical History

Current Medical Complaint

List the medical problems for which you use or would like to use medical marijuana; please provide details. Let us know if you need more space.

____
____
____
____
____

Who takes care of your for your medical issues [Fill in all that apply]

Name________________ ☐ Doctor
Business________________ ☐ Chiropractor
Phone________________ ☐ Accupuncturist
Address________________ ☐ Massage Therapist
City________________ Zip________ ☐ Psychologist or Counselor
May we contact them ? ☐ Y ☐ N ☐ Other________

Name________________ ☐ Doctor
Business________________ ☐ Chiropractor
Phone________________ ☐ Accupuncturist
Address________________ ☐ Massage Therapist
City________________ Zip________ ☐ Psychologist or Counselor
May we contact them ? ☐ Y ☐ N ☐ Other________

Name________________ ☐ Doctor
Business________________ ☐ Chiropractor
Phone________________ ☐ Accupuncturist
Address________________ ☐ Massage Therapist
City________________ Zip________ ☐ Psychologist or Counselor
May we contact them ? ☐ Y ☐ N ☐ Other________

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Medications [Prescription, herbal and Over-the-Counter]

☐ No current medications ☐ Yes - Current medications listed

Medication	Dose	Route	Oral	Topical	Injection	Other	
Medication______	Dose______	Route	☐	☐	☐	☐	______
Medication______	Dose______	Route	☐	☐	☐	☐	______
Medication______	Dose______	Route	☐	☐	☐	☐	______
Medication______	Dose______	Route	☐	☐	☐	☐	______
Medication______	Dose______	Route	☐	☐	☐	☐	______
Medication______	Dose______	Route	☐	☐	☐	☐	______
Medication______	Dose______	Route	☐	☐	☐	☐	______
Medication______	Dose______	Route	☐	☐	☐	☐	______
Medication______	Dose______	Route	☐	☐	☐	☐	______
Medication______	Dose______	Route	☐	☐	☐	☐	______

Allergies

☐ No known allergies
☐ Yes - Known allergies - list all medications, Foods, Environmental Allergies, etc…

______
______
______
______

Surgeries

☐ No surgeries ☐ Yes - List surgeries below

Surgery	Month	Year

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Other Treatments [Check any other treatments you use for your condition]

☐ Surgery
☐ Physical Therapy
☐ Chiropractic
☐ Massage
☐ Herbal Therapy
☐ Counseling
☐ Exercise
☐ Other_____

Do you have or have you ever had any of the following medical problems?

☐ Asthma / Lung Disease
☐ Cancer
☐ HIV / AIDS
☐ Diabetes
☐ Hepatitis
☐ Epilepsy / Seizures
☐ Stroke
☐ Liver Disease
☐ Kidney Disease
☐ High Blood Pressure
☐ Heart Disease
☐ ADD / ADHD
☐ Substance Abuse
☐ Intestinal Disorders [IBS, Ulcers]
☐ Multiple Sclerosis
☐ Mental Health Problems
☐ Sleep Disorders [Sleep Apnea, Insomnia]

Female Patients Only

	Y	N	
Are you pregnant?	☐	☐	# Weeks_____
are your currently breastfeeding?	☐	☐	

Physical / Social History

Exercise

☐ None
☐ Moderate
☐ Heavy
Days/week:_____

Work Activity

Y	N	
☐	☐	Sitting
☐	☐	Standing / Bending
☐	☐	Light Labor
☐	☐	Heavy Labor

Drug and Alcohol History

Y	N	
☐	☐	Tobacco Cigaretts / day _____
☐	☐	Alcohol Drinks / week _____
☐	☐	Caffeine Drinks / day _____
☐	☐	Cocaine / Meth
☐	☐	Hallucinogens [Ecstasy, LSD, Mushrooms]
☐	☐	Other_____

General

Y	N	
☐	☐	High Stress_____

	Y	N	N/A
Would you like help quitting?	☐	☐	☐

_____
_____
_____
_____
_____
_____

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Authorized Facility Signature _____ Date _____

Marijuana History

Have you been evaluated by another physician for medical marijuana?

☐ Y ☐ N If yes, where and when?_____

Do you use marijuana to reduce or eliminate the use of any medications that have been prescribed for your medical condition?

☐ Y ☐ N If yes, which medications have you reduced or eliminated and why?_____

How often do you use marijuana?

☐ Several times a day
☐ Every day or almost every day
☐ About 1 - 2 times a week
☐ More than once a month
☐ Less than once a month

What is your preferred method of using marijuana?

☐ Smoke
☐ Vaporize
☐ Ingest
☐ Topical
☐ Other _____

How effective is marijuana for your medical problem?

☐ Very effective
☐ Effective
☐ Only somewhat effective

I understand that the information I have been asked to provide is for the diagnosis and treatment of the medical condition for which I am seeing the physician today, and that if I have not accurately and completely disclosed the requested information, it may adversely impact the physician's ability to diagnose my condition and recommend appropriate treatment. I certify that the information in this questionnaire is accurate and complete.

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Important Patient Acknowledgments

By signing this page, you are acknowledging that:

1. The physician, staff, and/or representatives of Burns Integrative Wellness Center are neither providing nor dispensing medical marijuana.

2. Burns Integrative Wellness Center's physician will NOT be providing or discussing information regarding dispensary, co-op, delivery service, or any other way to obtain marijuana.

3. The physician, staff, and representatives of Burns Integrative Wellness Center are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider.

4. Should an approval be made for my medical use of cannabis, there is a renewal date specified by the physician. It is my responsibility to see the physician to re-evaluate possible continuance of cannabis use beyond the term of the approval.

5. I am a resident of Arizona and have not misrepresented any information to Burns Integrative Wellness Center.

6. I am not an agent of law enforcement, state, or federal government here for the purpose of investigation or entrapment.

7. I am not recording any portion of my visit with Burns Integrative Wellness Center nor do I possess any recording equipment. I understand Burns Integrative Wellness Center does not approve such action.

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Informed Consent

By signing below, you acknowledge that you have been informed of and understand the following:

I am being evaluated for a physician's recommendation for marijuana. The physician will make this determination based, in part, on the medical information I have provided. I have not misrepresented my medical condition in order to obtain this recommendation and it is my intent to use marijuana only as needed for the treatment of my medical condition, not for recreational or non-medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use, sale/purchase and/or distribution of marijuana.

I must be a Arizona resident to obtain an approval or recommendation for the use of cannabis [medical marijuana] under Arizona's AMMA [A.R.S. Title 36, Chapter 28].

Marijuana has not yet been approved by the Food and Drug Administration. Therefore, marijuana sold for medical use is not subject to any standards, quality control, or other oversight. Marijuana may contain unknown quantities of active ingredients (i.e., can vary in potency), impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

The use of marijuana can affect coordination, motor skills, and cognition, i.e., the ability to think, judge, reason and act. While using marijuana, I should not drive, operate heavy machinery, or engage in any activities that require me to be alert and/or respond quickly. I understand that if I drive while under the influence of marijuana, I can be arrested for "driving under the influence."

Potential side effects from the use of marijuana include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low blood pressure, impairment of short-term memory, euphoria, difficulty in completing complex tasks, suppression of the body's immune system, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression, and/or restlessness. Marijuana may exacerbate schizophrenia in persons predisposed to that disorder. In addition, the use of marijuana may cause me to talk or eat in excess, alter my perception of time and space, and impair my judgment.

I understand that using marijuana while under the influence of alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.

I understand that I may contact my primary care physician or 911 if I experience any of these side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. I will also contact my primary care physician or 911 if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends.

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Informed Consent [Continued]

By signing below, you acknowledge that you have been informed of and understand the following:

Smoking marijuana may cause respiratory problems and harm, including bronchitis, emphysema, and laryngitis. In the opinion of many researchers, marijuana smoke contains known carcinogens [chemicals that can cause cancer] and smoking marijuana may increase the risk of respiratory diseases and cancers in the lung, mouth, and tongue. In addition, marijuana smoke contains harmful chemicals known as tars. If I begin to experience respiratory problems when using marijuana, I will stop using it and report my symptoms to a physician. The physician will inform me of alternatives to smoking marijuana.

The risk, benefits, and drug interactions of marijuana are not fully understood. If I am taking medication or undergoing treatment for any medical condition, I understand that I should consult with my treating physician[s] before using marijuana and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating physician[s].

Individuals may develop a tolerance to, and/or dependence on, marijuana. I understand that if I require increasingly higher doses to achieve the same benefit or if I think that I may be developing a dependency on marijuana, I should contact my primary care physician or seek professional help. Signs of withdrawal can include: Feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances, and unusual tiredness.

Symptoms of marijuana overdose include, but are not limited to: nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in the hands, feet, arms, or legs, anxiety attacks, and incapacitation. If I experience these symptoms, I should contact my primary care physician, dial 911 or go to the nearest emergency room.

If Burns Integrative Wellness Center subsequently learns that the information I have furnished is false or misleading, the recommendation for marijuana may be revoked. I agree to promptly meet with and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided.

I will have the opportunity to discuss these matters with the physician and to ask questions regarding anything I may not understand or that I believe needs to be clarified.

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Agreement to Provide Medical Records or Establish Care

I hereby agree to provide medical records dated within the last 12 months that support my qualifying condition.

If I don't have or cannot provide said records, I agree to establish care at Burns Integrative Wellness Center.

In order to establish care, I will return for at least one follow-up visit with a doctor at Burns Integrative Wellness Center. In addition, I understand that I may be required to obtain imaging or lab results in order to support the diagnosis.

Cancellation Policy

To better serve our patients, we require 24-hour notice if an appointment is to be canceled or rescheduled. This will ensure maximum availability to all patients who need to see us.

We charge a $50 fee for any appointment canceled or rescheduled with less than 24-hours notice.

Prescription Refill Policy

Burns Integrative Wellness Centerwill call in prescription refills within 48 hours of receiving the request on business days, Monday through Friday, except for holiday schedules. Please plan your refills accordingly.

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Consent for Use and Disclosure of Health Information

We here at Burns Integrative Wellness Centerare very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information

1. We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
3. We may need to use your health information within our practice for quality control or other operational purposes such as recall notices, reminder calls, and treatment news.

Burns Integrative Wellness Center, it's staff or employees, may from time to time schedule appointments for other healthcare providers, when requested. These providers are not partners or contractors of Burns Integrative Wellness Center. All health and patient information disclosed to Burns Integrative Wellness Center, it's employees or staff, shall remain confidential and we will ensure that all federal and state laws pertaining to confidentiality of patient health information, including HIPAA, are complied with.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding.

Your Right to Revoke Your Authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke authorization. If you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

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