Copper Valley Medical
Caring, Compassionate Healing

Patient Information

Patient Name: _____ Date of Birth_____ Age _____ Gender M F

___New Card ___ Renewal

Acceptable Identification
(Only ONE is Required)

__ Az DL or ID or one of the following:
___ US Birth Certificate
___ US Certificate of Naturalization
___ US Certificate of Citizenship
__Az Registry Card
__Photograph Page of US Passport

ID Number: _____

Date of Issue: ___/____/_____

Expiration Date: ___/___/_____

Qualifying Conditions – Medical Records are required

__ Acquired immune deficiency syndrome (AIDS)
__ Human immunodeficiency virus (HIV)
__ Agitation of Alzheimer's disease
__ Amyotrophic lateral sclerosis (ALS)
__ Cancer
__ Crohn's disease
__ Glaucoma
__ Hepatitis C
__ PTSD

Chronic or debilitating disease/medical condition which causes:
__ Cachexia or wasting syndrome __ Severe nausea
__ Severe and chronic pain
__ Seizures, including those characteristic of epilepsy
__ Severe or persistent muscle spasms, including multiple sclerosis

Residential Address: _____Az_____
Street Number City Zip

_____
County of Residence:

Mailing Address: __ Same as Residence If not the same as the residential address:

_____Az_____
Street Number City Zip

Home Phone: (_____) _____ - _____ Mobile Phone: (_____) _____ - _____

Email Address: _____@_____

May we send you a reminder postcard for next year? **Y N**
Are you currently receiving Supplemental Nutritional Assistance? **Y N**
Requires one of the following: __ Eligibility Notice __ Electronic Benefits Transfer Card (Name Embossed)

Please tell us how you found out about us:
__ Web site __ Patient Brochure __ Print Ad(s): _____
__Referral by physician: _____
__Referral by patient: _____ __Other: _____

The following is required of all patient applications:
__ Current Photograph of the Patient
__ Signed, dated "Medical Marijuana Attestation" form
__ Medical Records from the past 12 month
__ Acceptable Identification
__ Payment of the Fee (VISA, MasterCard)
State Fee: $150 $75 (SNAP)
Office Fee: $135.00

_____
Signature of Patient Date

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Patient Name_____

Severe and Chronic Pain Patients

Severity of Pain (1-10)

What is the nature of your pain?

- Headache 1…3…6 7 8 9 10
- Neck 1…3…6 7 8 9 10
- Upper Back 1…3…6 7 8 9 10
- Mid Back 1…3…6 7 8 9 10
- Lower Back 1…3…6 7 8 9 10
- Sciatic Pain R L 1…3…6 7 8 9 10
- Knee R L 1…3…6 7 8 9 10
- Ankle R L 1…3…6 7 8 9 10
- Foot R L 1…3…6 7 8 9 10
- Shoulder R L 1…3…6 7 8 9 10
- Elbow R L 1…3…6 7 8 9 10
- Wrist R L 1…3…6 7 8 9 10
- Hand R L 1…3…6 7 8 9 10
- Abdomen 1…3…6 7 8 9 10
- Other_____ 1…3…6 7 8 9 10
- Other_____ 1…3…6 7 8 9 10
- Other_____ 1…3…6 7 8 9 10
- Other_____ 1…3…6 7 8 9 10
- Other_____ 1…3…6 7 8 9 10

What was the origin of your pain?

- Motor Vehicle Accident: Date_____
- Work Accident: Date_____
- Sports Injury: Date _____
- Congenital
- Unknown
- Other:_____

Have you seen other doctors for this? Y N

- If yes, Diagnosis:_____

What treatment have you had for your pain?

- Surgery Date:_____
- Other Procedure: _____

What medications have been prescribed?

_____

Are you currently restricted by a Pain Management Contract? __ Y __ N

- If yes, will Medical Marijuana violate the contract? __Y __N

For Patients with Other Conditions

HIV/AIDS: Date of Diagnosis _____
Most recent CD4 Count: _____

ALS: Date of Diagnosis _____

Cancer: Date of Diagnosis _____

- Type/Location_____
- Treatments_____

Crohn's Disease: Date of Diagnosis _____

Glaucoma: Date of Diagnosis _____

Hepatitis C: Date of Diagnosis _____

PTSD: Date of Diagnosis _____

- Current treatment __ Yes __No
- Name of Provider: _____

Patients with Other Chronic or Debilitating Conditions

Cachexia/Wasting Syndrome:

- Original or Normal Weight:_____
- Weight Loss: _____
- Time Period:_____
  (i.e., 25 pounds in 3 months)

Severe Nausea:

- Frequency of Nausea: _____
- Results of Nausea: _____
- Cause of Nausea:_____

Seizures:

- Initial seizure: _____
- Most recent seizure: _____
- Seizures in the past year:_____
- Diagnosis: _____

Muscle Spasms:

- Diagnosis:_____
- Treatment: _____