420 Plymouth Rd
Plymouth Meeting, PA 19462
(484) 531-4420
www.ilerahealthcare.com

New Patient Intake Form

DEMOGRAPHIC INFORMATION

Today's Date: _____

Patient Name: _____
(First) (Last)

Date of Birth: _____/_____/_____
(MM) (DD) (YYYY)

Address: _____
(Street)

_____
(City) (State) (Zip)

Phone Number:

(_____) _____-_____

Permission to leave voicemail?
☐ YES ☐ NO

Email:
_____

PA Department of Health Certified Caregiver Name (if applicable):

_____

Caregiver Phone:

(_____)_____-_____

Caregiver Relationship to Patient: _____

Permission to discuss information with family or other caregivers?
☐ YES ☐ NO
If yes, please provide name and contact information: _____

How did you hear about Ilera Healthcare?
☐ Physician ☐ Event ☐ Friend/Family ☐ Social Media ☐ Other:

MARIJUANA CERTIFICATION

Medical Marijuana Card Issue Date: ____/____/____ Expiration Date: ____/____/_____
(MM) (DD) (YY) (MM) (DD) (YY)

Name and Specialty of Approved Certifying Physician: _____

Certifying Physician's
Phone:(_____)_____ Facility Location: _____

Permission to discuss information with certifying physician?
☐ YES ☐ NO

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MEDICAL HISTORY	
I have the following approved medical condition(s) for medical marijuana in Pennsylvania:	
▫ Amyotrophic Lateral Sclerosis	▫ Intractable Seizures
▫ Autism	▫ Multiple Sclerosis
▫ Cancer, including remission therapy	▫ Neurodegenerative Diseases
▫ Crohn's Disease	▫ Neuropathies
▫ Damage to the nervous tissue of the central nervous system (brain-spinal cord) with objective neurological indication of intractable spasticity, and other associated neuropathies	▫ Opioid Use Disorder for which conventional therapeutic interventions are contraindicated or ineffective, or for which adjunctive therapy is indicated in combination with primary therapeutic interventions
▫ Dyskinetic & spastic movement disorder	▫ Pain – Severe chronic or intractable pain of neuropathic origin or severe chronic or intractable pain
▫ Epilepsy	▫ Parkinson's Disease
▫ Glaucoma	▫ Post-Traumatic Stress Disorder (PTSD)
▫ HIV/AIDS	▫ Sickle Cell Anemia
▫ Huntington's Disease	▫ Terminal Illness
▫ Inflammatory Bowel Disease	

Please list **any other medical conditions** you are currently under treatment for and/or **past surgical procedures**:

_____

_____

Are you pregnant, trying to become pregnant or breastfeeding? Yes_____ No_____

Please list **any prescription medications** you are currently taking, **including** over the counter, vitamins, and supplements:

MEDICATION NAME	STRENGTH	HOW OFTEN	REASON FOR TAKING

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SOCIAL HISTORY

Have you used marijuana in the past?	☐ YES	☐ NO
Are you currently using marijuana?	☐ YES	☐ NO
If "YES", how often? _____ per month	_____ per week	_____ per day
Do you use any form of nicotine?	☐ YES	☐ NO
If "YES", what form and how often?	Nicotine type: _____	Nicotine Usage: _____ per _____
Do you drink alcohol?	☐ YES	☐ NO
If "YES", how often?	Alcohol Usage: _____ drinks per _____	
Do you use any other substance? (ex: opioids not prescribed to you, cocaine, LSD, etc.)	☐ YES	☐ NO
If yes, what form and how often?	Substance type: _____	Substance Usage: _____ per _____

Other Comments: _____

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FOR OFFICE USE ONLY

Date of Initial Consult: _____

30-day DOH limit: _____ g per 30 days

30-day limit set initially set by Ilera HCP?

☐ YES ☐ NO

Name of Dispensary Employee for Initial Intake:
_____

Signature of Dispensary Employee:
_____

Comments: