

New Patient Appointment Packet

Hello and welcome to our practice. Please read this page carefully and follow the instructions. Your cooperation is greatly appreciated.

- ✓ Fill out the following pages and bring them with you to your appointment. **Do not send them back to our office.**
- ✓ Please **pre-pay** for your appointment. See below for details.
- ✓ We will call you to confirm your appointment 24 hours in advance.
- ✓ Please arrive 10 minutes early. Please find a comfortable spot to wait (waiting room, if applicable) and your practitioner will find you when it is your appointment time.

Appointment time	Provider	Location
	Diane Dickinson, MD	Arcata Crescent City
	Ken Miller, MD	Garberville
	Lorraine Carolan, PA	Happy Camp

Appointment Cost:

A **prepayment** of \$150 (money order only) is due **prior** to your visit.

Send a **money** order to our P.O. Box in Bayside. Please make it out to **North Coast Medical** (be sure to include your name and appointment date on the money order).

Cancellation policy:

Call us within 48 hours if you must cancel. Anything less than 48 hours may result in a \$25 fee to reschedule.

No-Show Policy:

If you miss your appointment and fail to call us, a **\$50 no-show fee will be due PRIOR** to your rescheduling an appointment.

We are a very busy office and wish to serve our patients as efficiently as possible. Thank you for your patience and cooperation.

Clinic offices:

1448 G Street Arcata, CA 95521
1080 Mason Mall, Ste 8B, Crescent City, CA 95531
867 Redwood Drive, Suite D, Garberville, CA 95542
707-822-1165 // 707-822-1553 FAX

IMPORTANT INFORMATION

APPOINTMENT LOCATION:

Arcata: 1448 G Street
Adjacent to the NorthCoast Chiropractic Building
Cross Street is 14th

Crescent City: 1080 Mason Mall, Suite 8B
Just off Front Street
between K Street and Price Mall

Garberville: Redwood Wellness Group
867 Redwood Drive, Suite D

Send all written correspondence to our mailing address:

North Coast Medical
P.O. Box 836
Bayside, CA 95524

Please arrive 10 minutes early for your appointment. Be prepared for your appointment by filling out this packet **prior** to arriving.

Worker's Compensation and Disability evaluations are very important. If you have these things please bring a copy to your appointment.

We do not review XRAYs. Please do not bring or arrange to have XRAYs sent to our office.

Your evaluation will require approximately 20 minutes.

A follow-up will be necessary, in most cases, within a year of this exam. You must call our office to schedule a renewal appointment. It is your responsibility to keep your 215 status current and up to date.

The validity of any advice or opinion rendered is subject to compliance with all applicable laws, consistent with your symptoms and/or diagnoses.

Diane Dickinson, MD

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Patient Identification Information

Name: _____
Last First M.I.

Mailing Address: _____

City, State, Zip: _____

Home Address (if different): _____

Gender: M ___ F ___ Height: _____ Weight: _____

Date of Birth: _____ Age: _____

Social Security Number: _____

Phone: Home _____

Cell _____

email _____

Marital Status: M ___ D ___ S ___ O ___

Education: High School ___ GED ___ College ___ Post Grad ___

Occupation/Profession: _____

Emergency Contact: _____ Phone: _____

Family Doctor: _____ Phone: _____

Today's Date: _____

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MEDICAL HISTORY I

Medical History

Surgeries (list type and date)

Medical illnesses (specify past and current)

Psychological illness and/or treatment, including counseling (specify past and current)

Trauma: vehicle accidents, falls, etc.

Medications: list (specify past and current)

Allergies to any medications (list)?

Social History

I am: married, single, divorced, re-married

Who do you live with? Alone spouse significant other relatives
housemate(s) Pets? Please list:

Cigarette use: pack per day ___ age began smoking ___ age quit ___ never smoked ___

Chewing Tobacco: how much per day?

Alcohol use: social ___ never had a problem ___ abused in the past for ___ yrs.

How much of what exercise do you do?

Family History

Mother: Alive/Deceased Age ___ Illnesses _____

Father: Alive/Deceased Age ___ Illnesses _____

Siblings: How many brothers? ___ How many sisters? ___ Any diseases?

Children (ages & health):

Is there a family history of high cholesterol, diabetes, high blood pressure, cancer, drug abuse, early heart disease, arthritis, psychiatric disease? Yes ___ No ___

Were your parents divorced? Yes ___ No ___
If so, how old were you? _____

Who raised you?

Were you raised as a child in an alcoholic or abusive home? (circle which) Yes ___ No ___

Who?: Mother father step-parent other
Have you lived in an alcoholic or abusive home? (circle which) Yes ___ No ___

MEDICAL HISTORY II

Do you have any problems related to your:

(Please circle what describes your health)

Head, eyes, ears, teeth, jaw, nose or throat:

Headaches migraines TMJ (jaw joints)
Have you been checked for glaucoma? Yes ___ No ___ If so,
when _____

Chest:

asthma (wheezing) heart murmur vascular disease leg cramps with exertion
exercise limitations swelling cholesterol high blood pressure

Stomach, liver, gall bladder, intestines, pancreas:

Poor appetite overeating weight gain or loss pains ulcer reflux
nausea diarrhea constipation change in bowel habits bleeding Stool blood test
(date) _____

Flexible sigmoidoscopy / colonoscopy / upper GI x-rays or endoscopy _____

Have you ever had Hepatitis? Yes ___ No ___
If so, which kind: A ___ B ___ C ___
Have you had a liver biopsy? Yes ___ No ___
Have you ever had treatment for hepatitis? Yes ___ No ___

Genital, Female:

Menstrual pain endometriosis PID HIV
Menses (period): age at onset _____ duration _____ frequency _____ regular? Yes ___ No ___
PAP smear (date) _____ Mammogram (date) _____
Pregnancy history:
Live births: 1 2 3 4 more
Abortions or miscarriages: 1 2 3 more

PROSTATE (MEN): Rectal exam (year) _____ PSA blood test (year) _____ prostate
trouble _____

Kidney and Bladder: Infection Stone Incontinence Other

Endocrine: thyroid trouble diabetes

Neurologic: MS neuropathy paralysis or weakness numbness
tremor stroke chronic fatigue other

Chronic Pain: Arthritis low back pain or sciatica neck pain arm or hand pain or numbness
shoulder wrist hand hip knee ankle foot pain fibromyalgia

Have you had: X-rays/CT/MRI of: neck back shoulder knee (please explain)

Psychological: counseling or therapy depression insomnia bulimia anorexia paranoia
Bipolar anxiety panic suicidal thoughts or attempts memory problems
social isolation anger poor job performance or inability to maintain a job
unsatisfactory relationships

Last name, First Name (Please Print)

EFFECTS OF CANNABIS & OTHER DRUGS

When using Cannabis, do you ever experience:	Antidepressants
<input type="checkbox"/> paranoia <input type="checkbox"/> anxiety <input type="checkbox"/> heart pounding <input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> sleep disturbance <input type="checkbox"/> loss of dreams <input type="checkbox"/> munchies <input type="checkbox"/> weight gain	<input type="checkbox"/> Celexa or Lexapro <input type="checkbox"/> Prozac <input type="checkbox"/> Luvox <input type="checkbox"/> Paxil <input type="checkbox"/> Zoloft <input type="checkbox"/> Effexor <input type="checkbox"/> Elavil <input type="checkbox"/> Trazodone
Have you been prescribed or have you used:	Anti-anxiety drugs
<input type="checkbox"/> Aspirin, Advil, Aleve, Celebrex, etc <input type="checkbox"/> Percodan or Percocet <input type="checkbox"/> Opiates <input type="checkbox"/> Codeine <input type="checkbox"/> Vicodin <input type="checkbox"/> Morphine <input type="checkbox"/> Oxycontin <input type="checkbox"/> Methadone	<input type="checkbox"/> Valium <input type="checkbox"/> Xanax <input type="checkbox"/> Klonopin <input type="checkbox"/> Ativan <input type="checkbox"/> Halcion <input type="checkbox"/> Ambien
Prescribed or non-prescription anti-nausea medications?	Seizure-type drugs
<input type="checkbox"/> Compazine <input type="checkbox"/> Phenergan	<input type="checkbox"/> Neurontin <input type="checkbox"/> Depakote <input type="checkbox"/> Other (please specify:) <input type="checkbox"/> Inderal or Propanolol
	Other

If you desire to become pregnant, become pregnant, or nurse, would you stop Cannabis use?

What precautions do you take to prevent unauthorized use of your Cannabis?

Last name, First Name (Please Print)

CANNABIS USE

Age when you began using Cannabis: <input type="checkbox"/> 10-20 <input type="checkbox"/> Over 40 <input type="checkbox"/> 20-30 <input type="checkbox"/> recently <input type="checkbox"/> 30- 40	Have you ever had a marijuana recommendation before? Yes___ No___ In California? Yes___ No___ N/A ___ Other State _____ Date_____
Why <u>did</u> you use cannabis? <input type="checkbox"/> recreational <input type="checkbox"/> occasional <input type="checkbox"/> relieve anxiety <input type="checkbox"/> other: <input type="checkbox"/> physical pain <input type="checkbox"/> help me: function, focus, relate	Have you ever been involved in legal action for any illegal drug or alcohol use? Yes___ No___
Preferred method of use: <input type="checkbox"/> water pipe <input type="checkbox"/> pipe <input type="checkbox"/> joint <input type="checkbox"/> food <input type="checkbox"/> tincture <input type="checkbox"/> vaporizer	Are you on Probation? Yes___ No___
On average, how often do you use Cannabis? <input type="checkbox"/> Daily times/day _____ <input type="checkbox"/> Weekly times/week _____ <input type="checkbox"/> Monthly times/month _____	Are you involved in any <u>work</u> or <u>court</u> required drug testing? Yes ___ No ___
How much Cannabis do you consume with each use? (1 joint = one gram) <input type="checkbox"/> less than a gram <input type="checkbox"/> 3-4 grams <input type="checkbox"/> 1-2 grams <input type="checkbox"/> over 4 grams	Have you ever been involved in a drug or alcohol treatment program? (see Drug Abuse questionnaire) Yes___ No___

Have you ever had problems related to your cannabis use? Explain

Has anyone suggested that your cannabis use is a problem? Explain

Have you ever been involved in any legal action regarding Cannabis? Yes___ No___ If yes, please provide details:

Are you currently involved in any Cannabis legal action? Yes___ No___ If yes, please provide details:

I, _____, affirm that the above information is true and accurate to the best of my knowledge, and that any recommendation, certification, or approval associated with my use of Cannabis is contingent upon the accuracy of this information.

Signature _____ Date _____

PATIENT INFORMED CONSENT

Medical Cannabis, or Marijuana, is legal in California for use by patients with “serious disease”(see State Code 11362.7 at www.leginfo.ca.gov), but is illegal to use, possess or distribute under federal law.

1. California law defines "Serious medical condition" as any persistent medical symptom that:
 - (A) Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336) AND/OR
 - (B) If not alleviated, may cause serious harm to the patient's safety or physical or mental health.**
2. The law prohibits cannabis consumption in certain situations:
 - (a) Non-smoking areas (b) In or within 1,000 feet of the grounds of a school, recreation center, or youth center, unless the medical use occurs within a residence, (c) On a school bus, (d) While in a motor vehicle that is being operated, (e) While operating a boat.
- 3. Penalties of from 6-12 months in jail and up to \$1000 fine for materially misrepresenting a medical condition to a physician, or employing fraud to obtain a medical certificate/ID card.**

- Cannabis can be intoxicating, impair behavior, and aggravate those effects from other drugs, including alcohol and opiates, such as codeine.
- Cannabis may cause unknown and undesirable interactions with other medications.
- Cannabis use can be associated with acutely unpleasant effects, such as disorientation, antisocial feelings, anxiety, sleep disturbances, or paranoia.
- Frequent use may result in social dysfunction, memory and sleep disturbances, and fatigue.
- Smoking may cause bronchitis or cancer.
- As with any medication, Cannabis should be avoided during pregnancy and breastfeeding.
- Men and women should be aware that any medication can affect fertility, and the incidence of ectopic pregnancy, birth defects and developmental disorders.
- The benefits, effects, risks and side effects of Cannabis are largely unknown or unproven.
- This approval is contingent upon my agreement to avoid any use which could reasonably pose a danger to myself or others, including, but not limited to, use of Cannabis while operating a vehicle or machinery, or engaging in inherently dangerous activities.
- I assume full responsibility for my use of medical Cannabis, and release Dr. Dickinson and her agents/contractors from any liability and for any consequences of my voluntary medical cannabis use.
- Dr. Dickinson DOES NOT PROVIDE ANY PRIMARY CARE SERVICES.**

I, _____, have read and understand the above, and agree to the constraints imposed therein. This certificate establishes that the consulting physician has approved of my use of medical Cannabis as a reasonable and possibly preferable alternative in combination with, or instead of, other legal options. I understand that this approval is provided conditional upon my compliance with all applicable laws. ***I agree to refrain from illegal drug use or diversion.***

I hereby authorize Dr. Dickinson to verbally verify the authenticity of this medical Cannabis approval upon request from law enforcement, public health officials, and Cannabis Clubs.

Signature _____ Date _____

North Coast Medical

Diane Dickinson, MD

P.O. Box 836

Bayside, CA 95524

northcoast-medical.com

VAPORIZING, AND OTHER WAYS TO AVOID SMOKE

Smoke, even if cooled, is irritating to the mouth and air passages. Cannabis smoke contains carcinogens (cancer-causing agents).

Fortunately, there is an alternative to smoking cannabis called vaporizing that avoids nearly all carcinogens but offers the rapid relief previously found only by smoking. Cannabis releases medicinal vapors above 140 C (284 F) but doesn't release benzene and other carcinogens until it reaches 200 C (392 F), and will not combust (burn or release smoke) until it reaches 230 C (446 F).

This means if a device gently cooks cannabis at 140 to 190 C (284 to 374 F), one can inhale the herbal medicine in the smokeless vapor without inhaling the carcinogens found in smoke.

However, some persons do not tolerate inhaling any medicine.

One way to minimize the risk of irritation to the airways is to ingest cannabis by mouth. Cannabis must be heated to be activated, and can be cooked into foods. Cannabis tinctures, both alcohol and non-alcohol based, act more quickly than ingested Cannabis. Ingested and tinctured Cannabis require an hour or so to take effect, but the effects can last 4-8 hours, or more.

The long duration of action of ingested or tinctured Cannabis is useful for people treating predictable symptoms. Some people are intolerant of the more psycho-active effects from ingested and tinctured Cannabis. This effect is related to the body's transformation of a component of Cannabis into a different active compound.

Newer routes of medical Cannabis are in development, and include transdermal devices (skin patches), and inhalers. Topical application of Cannabis poultices (moist mixtures of Cannabis, using oils, and heated, as above) provide relief to localized areas of pain, such as neck, low back, or arthritic joints).

Search the internet for **Marijuana Vaporizer** for more extensive information.