HAVEN

Confidential Record: Information contained here will not be released unless you have authorized us to do so.

Patient's Name _____
First Middle Last

Current Address_____
Street & Apt. #. City State Zip

Contact Number _____ Email Address _____
The above information is accurate and complete to the best of my knowledge.

Signature _____ Date _____

1. What is your history of using cannabis?

Level 0 No Tolerance Has usually never used product; Used "back in the day"; Haven't used it in at least a year; Or at most one to two times per month	Level 1 Slight Tolerance Uses cannabis four to ten times a month; Does not need much cannabis to achieve their desired effects; Does not need to purchase large quantities of product	Level 2 Moderate Tolerance Uses cannabis 14 - 100 a month; Product is a daily part of life; Use for a variety of reasons; Knows products well	Level 3 Strong Tolerance Several, if not many times a day - 100s of times of month; Don't need products explained; May need to be concerned about extreme levels of usage

2. What is the main symptom you are trying to relieve?

3. Would you like to review methods of administration to determine the best option? Yes No

Preference for administration (if known):

Sub-lingual	Topical	Vaporizer Pen	Other

Emergency Contact (Other than Caregiver):

Emergency Contacts Name (First Middle Last) _____

Contact Number _____