Appt. Time: _____	Date: _____			NEW	RENEWAL	
Cost of Service: $_____	Service :	$125	$150	$175	Pre-Registration :	$25
PAID WITH: CASH ☐					Location: HOLLAND	

PURE WEST
840 N Black River Dr Suite 90
Holland, MI 49424
616-772-4422
purewestclub@gmail.com

OFFICE NOTES: _____
_____
_____

CK IN _____ QUE CK _____ CK OUT _____

PATIENT GENERAL INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ Apt #: _____ Date Of Birth: _____

City: _____ State: _____ Zip: _____ Sex: Male ☐ Female ☐

DL: _____ Phone No.: _____ E-Mail: _____

Are you a Veteran? Yes ☐ No ☐

Emergency Contact: Name: _____ Phone No. _____

How did you hear about PURE WEST (please be specific).
Google Search ☐ Get Legal America ☐ Marijuana Doctors.com ☐
Leafly ☐ Weed Maps ☐ MMMP Report ☐

Other: _____

Is this CERTIFICATION with MMMP: NEW ___ **or** RECERTIFICATION ___

Will you have a caregiver? ☐ Yes ☐ No

If yes, provide First Name _____ Middle Initial: ___ Last Name _____ **D.O.B** _____

Address: _____ Apt#: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone No: _____ Sex: ____Male ___Female Email _____

PATIENT PRE-QUALIFICATION FOR THE MICHIGAN MEDICAL MARIJUANA PROGRAM

The following conditions are qualifications for the MMMP program.
Please select the condition(s) you are seeking qualifications for the MMMP program.

Amyotrophic Lateral Sclerosis: ☐	Glaucoma: ☐	Severe Nausea: ☐
Agitation of Alzheimer's: ☐	HIV/AIDS: ☐	Seizures: ☐
Arthritis: ☐	Multiple Sclerosis: ☐	Chronic Pain: ☐
Cachexia Disease: ☐	Nail Patella: ☐	Severe Pain: ☐
Crohn's Disease: ☐	Muscle spasms: ☐	Hepatitis C: ☐
Cancer: ☐	Persistent Migraines: ☐	Post-Traumatic Stress Disorder: ☐

Other _____

Hospitalizations? _____

Surgeries?_____

Previous counseling? With Whom?_____ When?_____

Suicidal Ideation?_____ Sleep or Appetite Problems?_____

Serious Accidents?_____

Infectious Diseases?_____ If Yes, Please describe_____

Allergies or Adverse Reactions?_____ If Yes, Please Describe_____

How Long Have You Been Experiencing Your Symptoms? _____

How Long Have You Been Receiving Treatment for this Condition? _____

Do you smoke Marijuana? Yes [ ] No [ ] Has Marijuana helped with your condition? Yes [ ] No [ ]

Explain your Marijuana use and results _____

_____

_____

Are You Allergic to Any Medications?_____ If Yes_____

Do You Currently Take Prescription Medication? Yes [ ] No[ ]

Please List ALL Medications that you are currently taking. If You Already Have a List Prepared, You May Leave This Area Blank And Submit Your List To The Doctor.

Name of Medication	Dosage	Condition Used For

What is the name and address (city is fine) of the doctor(s) that you have seen for the condition(s)?

1 . _____

2 . _____

3. _____

I Hereby Certify That All The Information That I Have Provided On This For Is True And Accurate

_____ _____

Signature Date

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Patient Name: _____ **Date of Birth:** _____

General: Mark if you have had any of the following in the past 3 months

- ☐ Fever
- ☐ Weight Gain
- ☐ Chest Pain
- ☐ Chills
- ☐ Weight Loss
- ☐ Difficulty Breathing
- ☐ Night Sweats
- ☐ Marked Fatigue
- ☐ Nausea or vomiting
- ☐ Dizziness

Social History

- ☐ Smoker
- ☐ Other tobacco products
- ☐ Street Drugs (Other than Marijuana, strictly confidential)
- ☐ Alcohol _____ Daily _____ Weekly

Please mark diseases, symptoms or other items corresponding to your current and past health Problems:

Eyes, Ears, Nose, Throat

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Hearing Loss ☐ Left ☐ Right ☐ Both
- ☐ Frequent Ear Infections
- ☐ Seasonal Allergies
- ☐ Sinus Problems
- ☐ Difficulty Swallowing
- ☐ Eye Pain
- ☐ Other_____

Cardiovascular

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Attack
- ☐ Angina
- ☐ Cardiac Arrhythmias
- ☐ Palpitations
- ☐ Pace Maker
- ☐ Stroke (Lasting deficits)
- ☐ TIA (Symptoms resolved completely)
- ☐ Peripheral Vascular Disease
- ☐ Other_____

Respiratory

- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Chronic Bronchitis
- ☐ Pulmonary Embolism
- ☐ DVT (Blood Clot)
- ☐ Other Lung Problems_____

Integumentary

- ☐ Psoriasis
- ☐ Photosensitivity
- ☐ Skin Cancer
- ☐ Other Skin Problems_____

Gastrointestinal

- ☐ Chronic Constipation
- ☐ Chronic Diarrhea
- ☐ GERD
- ☐ Ulcers
- ☐ Heartburn
- ☐ Crohn's
- ☐ Colitis
- ☐ Cachexia or Wasting Syndrome
- ☐ Persistent Nausea
- ☐ Frequent Vomiting
- ☐ Blood in Stool
- ☐ Decreased Appetite
- ☐ Diverticulitis
- ☐ Other_____

Nervous System

- ☐ Migraine or other Headaches
- ☐ Nerve pain or Neuropathy
- ☐ Insomnia / Sleeping Disorder
- ☐ Parkinson's Disease
- ☐ Post Herpetic Neuralgia (Shingles pain)
- ☐ Head Injury
- ☐ Multiple Sclerosis
- ☐ Epilepsy/Seizures
- ☐ Severe and Chronic Pain
- ☐ Other_____

Renal

- ☐ Kidney Disease
- ☐ Require Dialysis
- ☐ Frequent Kidney Stones
- ☐ Other_____

Infectious Disease

- ☐ HIV/AIDS
- ☐ Hepatitis A B C
- ☐ Tuberculosis
- ☐ Valley Fever
- ☐ Other _____

Cancers

- ☐ Cancer : Type_____
- ☐ Cancer: Type_____
- ☐ Family History of Cancer diagnosed before age 50 yrs

***Are you currently or previously Treated with:*

- ☐ Chemotherapy
  Started:_____
  Duration:_____
  Treatments Per Week:_____
  End:_____

- ☐ Radiation Therapy
  Body Part:_____
  Start:_____
  Duration:_____
  End:_____

Metabolic/Endocrine

- ☐ Diabetes Type I or II (circle one)
- ☐ Thyroid Disorder
- ☐ Anemia
- ☐ Obesity
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Metabolic Syndrome
- ☐ Other:_____

Musculoskeletal

- ☐ Severe and Persistent Muscle Spasms
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Broken Bone: Where:_____
- ☐ Degenerative Disk Disease
- ☐ Rheumatoid Arthritis
- ☐ Other Arthritis
- ☐ Fibromyalgia
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Bone Pain
- ☐ Amyotrophic Lateral Sclerosis
- ☐ Other _____

Surgeries

- ☐ Tonsillectomy
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Other bone/joint surgery
- ☐ Procedure to decrease pain:_____
- ☐ Injections to treat painful areas
- ☐ Transplant Surgery
- ☐ Abdominal Surgeries
- ☐ Heart Surgery
- ☐ Other Surgery or Procedure_____

Mental Health

- ☐ Panic Disorder
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Alzheimer's Disease
- ☐ Dementia
- ☐ Obsessive-compulsive disorder (OCD)
- ☐ Post-traumatic stress disorder (PTSD)
- ☐ ADD/ADHD
- ☐ Suicidal thoughts, plans, or attempts
- ☐ History of abuse
- ☐ History of drug abuse
- ☐ Other_____

THIS SECTION FOR WOMEN ONLY:

- ☐ Could you be pregnant: YES NO
- ☐ Taking hormones
- ☐ Using oral contraceptive
- ☐ Pelvic Inflammation Disease
- ☐ Hysterectomy Full Partial Date:_____
- ☐ Ovaries Removed Date:_____
- ☐ Heavy Periods
- ☐ PMS or PMDD

- ☐ Trying to get pregnant YES NO
- ☐ Currently taking birth control
- ☐ Decreased Libido
- ☐ Hot Flashes
- ☐ Tubal Ligation Date:_____
- ☐ Natural Post Menopause Date of Last Period:_____
- ☐ Irregular Periods
- ☐ Other_____

THIS SECTION FOR MEN ONLY

- ☐ Decreased Libido
- ☐ Prostate Enlargement
- ☐ Problems Urinating
- ☐ Erectile Dysfunction
- ☐ Other _____

I certify that the above information is true and accurate to the best of my ability.

Signature (Required) _____ Date: _____

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"No marijuana-related legal action pending" Agreement

By signing below, I, _____, assert that as of today, the _____ day of _____ in the year _____,
I have NO marijuana-related legal issues pending in the courts of any level of government.

Examples of pending marijuana-related legal issues include, but are not limited to: unresolved misdemeanor or felony criminal charges stemming from the growing, possessing or operating a vehicle under the influence of marijuana, probation violation hearings concerning testing positive for marijuana activity (medical or otherwise) and civil actions against employers or former employers concerning termination of employment relating to your status as a medical marijuana patient.

I understand that according to the Michigan Medical Marihuana Act's affirmative defense outlined in MCL 333.76428(a)(1), a bona-fide patient-doctor relationship must be established by any defendant/patient who seeks to have his criminal charges successfully dismissed under the MMMA. I understand and agree that breaching this agreement will render null and void any bona-fide patient-doctor relationship that may have existed between myself and the physicians at Pure West Compassion Clinic at the time of service.

I also further assert that any and all information I give pertaining to my "qualifying condition" as defined by the State of Michigan, is accurate and complete.

I further understand that should an applicable court refuse to dismiss a pending criminal charge as a result of the contents of this agreement, I will hold Pure West Compassion Clinic harmless for the legal consequences associated with my potential sentence, incarceration, civil forfeiture, fines, restitution, court and attorney costs.

This agreement pertains to treatment and services provided by Pure West Compassion Clinic – a Michigan Corporation.

Signature of Patient _____ Date _____

Signature of Witness _____ Date _____

Pure West Compassion Clinic

PureWest
compassion clinic

Physician Release from all Liability Form

Signing this form releases the physicians of Pure West Club from all liability for providing a state of Michigan medical marijuana "Physician's Certification." And by signing this form, you, the patient-applicant, are stating that you understand and agree with the following statements of fact:

1. The federal Food and Drug Administration approves all drugs prescribed by physicians. Medical Marijuana is not an FDA approved medication. Crude marijuana is not standardized regarding its purity, strength or dosage size.
2. Therefore, the physicians of Pure West Club cannot write a prescription for medical marijuana and has no control over the ingredients or the effects or the adverse risks of whatever medical cannabis you decide to consume nor can they, in any way, help or tell you how to acquire or grow it. Please consult the internet or your local compassion club.
3. The physicians of Pure West Club may not be able to provide you with thoroughly researched conclusions regarding all the potential benefits and adverse risks of cannabis use for your particular qualifying medical condition. The scientific research on cannabis is incomplete and does not meet the high requirements for all other medicines approved by the FDA.
4. The physicians of Pure West Club cannot provide you with a regimen for the use of medical marijuana. You are solely responsible for administering medical marijuana as your condition warrants, as determined on the basis of your own judgment and are solely responsible for all the consequences.
5. Please take care if you have not used marijuana before. You are advised to keep a log of how much medicine you use and its effects on your symptoms. This will help you make adjustments to your dose and frequency.
6. You are in charge of the most comfortable and effective method of delivery – vaporizer, topical, smoking or edibles. (It is not advisable for patients with lung issues or smoke allergies to smoke marijuana.) These are general guidelines and should be used in conjunction with your own common sense and wisdom about your health.
7. The cultivation, possession and use of cannabis – even for medical purposes – remains a crime under federal law.
8. Medical marijuana is generally tolerated well by patients. Any side effects tend to be mild and temporary, usually lasting one week or less as patients adjust. Common side effects include irritated throat, dry mouth, elevated heart rate, mild time and space disorientation, mild euphoria, a general sense of well-being, and in some instances drowsiness and a motivation.

I, _____, agree not to make any legal claim or complaint, or commence any proceeding against Pure West Compassion Clinic. in providing me with a "Physician's Certification" as required by the Michigan Medical Marijuana Act. And I further agree not to make any legal claim or complaint or commence any proceeding against the same physician for my use of crude medical marijuana. I release the same physician from any and all actions, causes of actions, claims, complaints and demands for damages, loss of injury whatsoever arising directly or indirectly as a result of my medical marijuana application to the state of Michigan or my use of medical marijuana. This release of liability is to be binding on my heirs, executors and assigns. I have read, understand and agree with all the statements in this form.

_____ _____

Signature of applicant Date

_____ _____

Signature of witness Date

840 N. BLACK RIVER DR. SUITE #80 HOLLAND, MI 49424
(616) 772-9420 WWW.PUREWESTCLUB.COM EMAIL: PUREWESTCLUB@GMAIL.COM

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Your Follow Up Care

Please call us within 30 days to inform us how the program is working for you. As always, our business staff is available 5 days a week to answer any questions you may have. You can also email us at purewestclinic@gmail.com. We expect to provide follow-up care to you to monitor the efficacy of your medical use of marijuana.

As of April 1, 2013, the state is issuing two-year cards. However court cases in Michigan have held that a registry card—even one verified by the state-does not prove "ongoing" contact between the physician and patient.

For your protection, Pure West Compassion Clinic will need an annual appointment with you to maintain your doctor-patient relationship as required by the state. The charge for this annual appointment next year will be $79. We will review and assess your medical history and current medical conditions to determine that you are still likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat your condition. We will also discuss how well the program is working for you and offer recommendations for any additional care, such as alternative therapy.

_____ Patient Name (please print)

_____ Patient signature

_____ Date of birth

_____ Today's Date

THE PHYSICIAN MUST INITIAL EACH LINE BELOW:

I do hereby declare that the written certificate was prepared in the course of a bona fide physician-patient relationship in which each of the following were present as part of the treatment or counseling relationship:

____ I have reviewed this patient's relevant medical records and completed a full assessment of this patient's medical history and current medical condition, including a relevant, in-person, medical evaluation of this patient. (MCL333.26423(a)(1))

____ I have created and will maintain records of this patient's condition in accord with medically accepted standards.(MCL333.26423(a)(2))

____ I have a reasonable expectation that I will provide follow-up care to this patient to monitor the efficacy of the use of medical marihuana as a treatment of this patient's debilitating medical condition. (MCL333.26423(a)(3))

____ If the patient (or for minor: parent/legal guardian) has given permission, I have notified this patient's Primary care physician of this patient's debilitating medical condition and certification for the use of medical marihuana to treat that condition(MCL333.26423(a)(4))