TRILL EVOLUTIONS CLIENT INFORMATION FORM

Please fill out the following questions with the best-detailed answers that you feel comfortable with. We appreciate your time and want you to know that your responses will give us a better understanding on how we may assist your specific needs. This information is used for consultation purposes only. Please print legibly. Thank you!

#1 TODAY'S DATE:

#2 ARE YOU AN MMJ CARDHOLDER?
☐YES ☐NO
We can only make sales to Colorado MMJ cardholders

#3 WHO REFERRED YOU TO US?

#4 CLIENT NAME (or alias if preferred):

#5 AGE TODAY:

#6 HEIGHT & WEIGHT:

#7 PHONE NUMBER:

#8 E-MAIL:

#9 PREFERRED METHOD OF CONTACT:
☐E-MAIL ☐PHONE (VOICEMAIL OKAY)
**By providing us with contact information you are giving us your permission to contact you at these numbers and addresses for consultation purposes*

#10 BEST DAY TO CONTACT (PHONE):
☐S ☐M ☐T ☐W ☐H ☐F ☐S

#11 BEST TIME TO CONTACT (PHONE):
☐MORNING ☐LUNCH ☐NIGHT

#12 CITY OF RESIDENCE:

#13 PLEASE DESCRIBE YOUR AILMENT (S) / DIAGNOSIS:

#14 LIST SURGERIES/HOSPITALIZATIONS/HISTORY:

#15 PLEASE LIST CURRENT AND PAST MEDICATIONS AND SUPPLEMENTS (USE BOX #35 FOR ADDITIONAL SPACE)

DATES	MEDICATION NAME	DOSING	FREQUENCY	DETAILS

#16 PLEASE LIST ANY ALLERGIES:

#17 PLEASE MARK ALL THAT APPLY TO YOU:
☐ANXIETY ☐APPETITE & DIGESTIVE ISSUES ☐AUTO-IMMUNE DISEASES ☐CANCER ☐CHEMOTHERAPY ☐DEPRESSION ☐EPILEPSY/SEIZURES
☐HEADACHES/MIGRAINES ☐INFLAMMATION ☐INSOMNIA ☐NAUSEA ☐NERVE PAIN ☐NEUROPATHY ☐PAIN ☐PTSD
☐RHEUMATOID ARTHRITIS ☐SKIN CONDITIONS ☐SPASMS ☐ STRESS ☐OTHER:_____

#18 PLEASE LIST YOUR PRIMARY SYMPTOMS:

#19WHAT MAKES YOUR SYMPTOMS BETTER?

#20WHAT MAKES YOUR SYMPTOMS WORSE?

#21 HOW WOULD YOU RATE YOUR SYMPTOMS WITHOUT MEDICATION OR TREATMENT? 1 2 3 4 5 6 7 8 9 10

#22 HOW WOULD YOU RATE YOUR SYMPTOMS WITH MEDICATION OR TREATMENT? 1 2 3 4 5 6 7 8 9 10

#23 HOW FREQUENTLY DO YOU EXPERIENCE YOUR SYMPTOMS
☐ MONTHLY ☐WEEKLY ☐DAILY ☐WITH ACTIVITY ☐WITHOUT MEDICATION ☐OTHER:_____

#24 PLEASE MARK ALL THAT APPLY REGARDING YOUR DIET AND EATING HABITS:
☐LOW FAT ☐LOW CARB ☐LOW GLYCEMIC ☐HIGH PROTEIN ☐GLUTEN FREE ☐DAIRY FREE ☐MEAT FREE ☐RAW ☐PALEO ☐
OTHER:_____
NOTES:

#25 HOW FREQUENTLY DO YOU PHYSICALLY EXERCISE?:
☐ MONTHLY ☐BI-WEEKLY ☐A FEW TIMES WEEKLY ☐MANY TIMES WEEKLY ☐DAILY ☐
OTHER:_____

#26 PLEASE DESCRIBE YOUR SLEEPING HABITS. HOW MANY HOURS DO YOU SLEEP EACH NIGHT?:

#27 PLEASE MARK ALL THAT CURRENTLY APPLY TO YOU:

☐CANNABIS USE ☐PERSCRIPTION MEDICATIONS ☐CAFFEINE USE ☐TOBABCCO USE ☐ALCOHOL USE ☐OTHER:_____

#28 HOW WOULD YOU RATE YOUR LEVEL OF EXPERIENCE WITH CANNABIS?

☐NEW PATIENT ☐LITTLE EXPERIENCE ☐SOME EXPERIENCE ☐VERY EXPERIENCED ☐OTHER:_____

#29 HOW LONG HAVE YOU BEEN USING CANNABIS MEDICINALLY? DESCRIBE YOUR MEDICINAL CANNABIS HISTORY:

#30 WHAT IS YOUR GOAL OR INTENTION WITH CANNABIS TREATMENT?

#31 WHAT CANNABIS DELIVERY METHODS HAVE YOU TRIED?

☐SMOKE ☐VAPORIZE ☐EDIBLE ☐CAPSULE ☐SUBLINGUAL ☐TOPICAL ☐TRANSDERMAL ☐HASH/"DAB" ☐OTHER:_____

#32 PLEASE LIST ANY SPECIFIC PRODUCTS YOU HAVE TRIED THAT WORKED FOR YOU:

PRODUCT/STRAIN	***DOSE TRIED***	***EFFECTS***

#33 PLEASE MARK ALL THAT YOU ARE INTERESTED IN LEARNING MORE ABOUT:

☐ENDOCANNABINOID SYSTEM ☐THC ☐CBD ☐ CBN ☐THCA ☐CBDA ☐HEMP ☐DOSING
☐SMOKE ☐VAPORIZE ☐EDIBLE ☐CAPSULE ☐SUBLINGUAL ☐TOPICAL ☐TRANSDERMAL ☐HASH/"DAB
☐OTHER:

#34 ARE YOU WILLING TO FILL OUT TESTIMONIAL SHEETS ABOUT YOUR EXPERIENCE (S) WITH CANNABIS MEDICATIONS?

☐YES ☐NO

#35 PLEASE USE THIS SPACE FOR ANY ADDITIONAL NOTES (OTHERWISE LEAVE BLANK):

PLEAE READ CAREFULLY AND SIGN BELOW

All responses have been filled out accurately to the best of my knowledge and understanding.

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For registered Colorado medical marijuana patients only.

PATIENT (PRINT NAME):	**PATIENT SIGNATURE:**	**DATE:**