CANNABINOID CONSULTATION

Date		**Your Name**	
Name of Patient		**Age**	
Tel No		**Email**	
How did you find us?			

CONDITIONS & SYMPTOMS: in full, leave nothing out.

Medication: (Full names, including Homoeopathic and Supplements)
Please include the dosage and how often you take it as well as how long it takes for you to feel the effect.

Lifestyle/Routine: Include diet, exercise and sleep.

DISCLAIMER

I, _____ (name of client and/or parent or gaurdian)
hereby acknowledge that before consulting with me. Canna I Heal U has made it clear to me that they:

- Do not diagnose or treat any named disease
- Do not have the authority to take me off any prescribed medication, that choice is entirely my own.
- May suggest advantageous lifestyle and nutrition options, it is my choice to follow the advice or not.

I have been advised that neither the producers of the cannabinoid products, its individual representatives or Canna I Heal U, will be legally liable or responsible for any risk of illness, injury or aggravation of any medical condition whatsoever that may occur out of the recommendations administered to me arising out of my failure to consult with, and obtain approval from, a registered medical doctor prior to commencing the program with Canna I Heal U. I hereby consent to such treatment and indemnify the producers, its members, representatives and Canna I Heal U against any and all claims by myself, my successors and assigns in this regard.

_____ _____
Signature of client or Parent/Guardian Date

_____
Witness