



**PATIENT INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Gender: \_\_\_\_\_ Personal Health Care Number: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

**INDICATION FOR CANNABIS**

Please check the medical condition(s) / problem(s) for which you wish to use medical cannabis

(Check all that apply):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> ADD/ADHD                       | <input type="checkbox"/> Crohn's Disease            | <input type="checkbox"/> Menopause                   |
| <input type="checkbox"/> Alzheimer's Disease            | <input type="checkbox"/> Degenerative Disc Disease  | <input type="checkbox"/> Migraines                   |
| <input type="checkbox"/> Anxiety                        | <input type="checkbox"/> Depression                 | <input type="checkbox"/> Multiple Sclerosis          |
| <input type="checkbox"/> Appetite                       | <input type="checkbox"/> Eating Disorders           | <input type="checkbox"/> Muscle Spasms               |
| <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Muscular Dystrophy          |
| <input type="checkbox"/> Osteoarthritis                 | <input type="checkbox"/> Essential Tremors          | <input type="checkbox"/> Nausea                      |
| <input type="checkbox"/> Psoriatic Arthritis            | <input type="checkbox"/> Fibromyalgia               | <input type="checkbox"/> Nerve Pain                  |
| <input type="checkbox"/> Rheumatoid Arthritis           | <input type="checkbox"/> Gastrointestinal Disorders | <input type="checkbox"/> Parkinson's Disease         |
| <input type="checkbox"/> Back and Neck Pain             | <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Pelvic Pain                 |
| <input type="checkbox"/> Bladder Pain                   | <input type="checkbox"/> Head Injury                | <input type="checkbox"/> Post Operative Surgery Pain |
| <input type="checkbox"/> Brain Injury                   | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> PMS/Menstrual Cramps        |
| <input type="checkbox"/> Cancer                         | <input type="checkbox"/> HIV/AIDS                   | <input type="checkbox"/> PTSD                        |
| <input type="checkbox"/> Cancer Symptoms                | <input type="checkbox"/> Irritable Bowel Syndrome   | <input type="checkbox"/> Repetitive Strain Injury    |
| <input type="checkbox"/> Chronic Pain                   | <input type="checkbox"/> Jaw Pain                   | <input type="checkbox"/> Seizures                    |
| <input type="checkbox"/> Colitis                        | <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> Sleep Disorders             |
| <input type="checkbox"/> Complex Regional Pain Syndrome | <input type="checkbox"/> Libido                     | <input type="checkbox"/> Spinal Cord Injury/Disease  |
| <input type="checkbox"/> Other:                         |   |  |

Explain ALL conventional therapies attempted to assist you with the management of your medical condition(s) in which you are seeking to use cannabis and explain how these treatments have not been successful.

**MEDICAL HISTORY**

Please give a brief description of your previous medical history:

List the name, last date seen and type of health care provider (Doctor, chiropractor, therapist, counselor, and/or specialist) that you consult for your medical condition(s):

Name	Date Last Seen	Type of Health Care Provider

**PSYCHIATRIC HISTORY**

Are you currently experiencing any of the following?

- Mania (bipolar disorder)       Yes     No
- Schizophrenia                 Yes     No
- Depression                     Yes     No
- Using Sedatives/psychoactive drugs     Yes     No

Are you currently or previously suicidal?     Yes     No

Do you have any history of substance abuse such as: alcohol, heroin, cocaine, LSD, marijuana, ecstasy, GHB, prescription drug abuse (narcotics or Benzo)?     Yes     No

**CURRENT PRESCRIPTIONS AND OVER THE COUNTER SUPPLEMENTS**


**PREVIOUS MEDICATIONS TRIED (Check all that apply)**

<input type="checkbox"/> Gabapentin	<input type="checkbox"/> Lyrica	<input type="checkbox"/> Anti-Anxiety
<input type="checkbox"/> Antidepressants	<input type="checkbox"/> Muscle Relaxants	<input type="checkbox"/> Antiinflammatories
<input type="checkbox"/> Narcotics/Opioids	<input type="checkbox"/> Methadone	<input type="checkbox"/> Lidocaine/Ketamine
<input type="checkbox"/> Nabilone	<input type="checkbox"/> Tramadol	<input type="checkbox"/> Sleep Medication
<input type="checkbox"/> Other:		

**ALLERGIES (Please list all allergies)**

**HISTORY**

Any history of heart attack, chest pain, stroke?  Yes  No

Are you pregnant or breastfeeding?  Yes  No

Do you have an allergy to cannabis?  Yes  No

Do you have chronic bronchitis (lung disease)?  Yes  No

Any history of high blood pressure? (hypertension)  Yes  No

Any history of low blood pressure? (hypotension)  Yes  No

Do you have children in the house or who visit?  Yes  No

If yes, how old are they? \_\_\_\_\_

Are you working outside of the home?  Yes  No

Do you work in a safety sensitive or cognitively demanding occupation?  
(ie. Construction work, heavy machinery, policeman, etc.)  Yes  No

Do you drive a car?  Yes  No

Do you travel outside of Canada?  Yes  No      Within Canada?  Yes  No

Are you on disability?  Yes  No      If yes, which one? (PWD, CPP, Workplan) \_\_\_\_\_

Is your annual income less than \$30,000?  Yes  No

If yes, bring in a notice of assessment as you will qualify for compassionate pricing.

**DRUG AND ALCOHOL HISTORY**

Do you have a previous history of smoking?  Yes  No

If yes, how many years? \_\_\_\_\_

Do you currently use:

Tobacco  Yes  No If yes, how many cigarettes per day? \_\_\_\_\_

Alcohol  Yes  No If yes, how many drinks per week? \_\_\_\_\_

Have you ever been evaluated by another physician for medical marijuana?  Yes  No

Do you use marijuana to reduce or eliminate the use of any medications that have been prescribed for your medical condition?  Yes  No

If yes, which medication(s) have you reduced or eliminated and why? Please include dosage details

How often do you use cannabis?

Everyday  Every other day  1-2 times per week  More than once a month  Other

How have you used cannabis? (Please check all that apply)

Smoking (joints)  Vaporizing  Ingestion  Topical

If you own a vaporizer, which vaporizer do you own? \_\_\_\_\_

Do you/did you use it recreationally \_\_\_\_\_ or for medical reasons? \_\_\_\_\_

What strains have you used? (Check all that apply)

Indica  Sativa  Hybrid  All

How much marijuana do you currently use per day, in grams? \_\_\_\_\_

How many times per day do you use cannabis? \_\_\_\_\_

Have you had any serious reaction to cannabis? \_\_\_\_\_

## Patient Health Questionnaire

( G A D - 7 )

Over the last 2 weeks, how often have you been bothered by the following problems?

Not at all

Several days

More than half the days

Nearly every day

(Use "✓" to indicate your answer)

1. Feeling nervous, anxious or on edge

0

1

2

3

2. Not being able to stop or control worrying

0

1

2

3

3. Worrying too much about different things

0

1

2

3

4. Trouble relaxing

0

1

2

3

5. Being so restless that it is hard to sit still

0

1

2

3

6. Becoming easily annoyed or irritable

0

1

2

3

7. Feeling afraid as if something awful might happen

0

1

2

3

(For office coding: Total Score T \_\_\_\_ = \_\_\_\_ + \_\_\_\_ + \_\_\_\_ )

## Patient Health Questionnaire

( P H Q - 9 )

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

*(Use "✓" to indicate your answer)*

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. Feeling tired or having little energy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. Poor appetite or overeating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

FOR OFFICE CODING   0   +        +       

+        =Total Score:       

**If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not difficult  
at all

Somewhat  
difficult

Very  
difficult

Extremely  
difficult

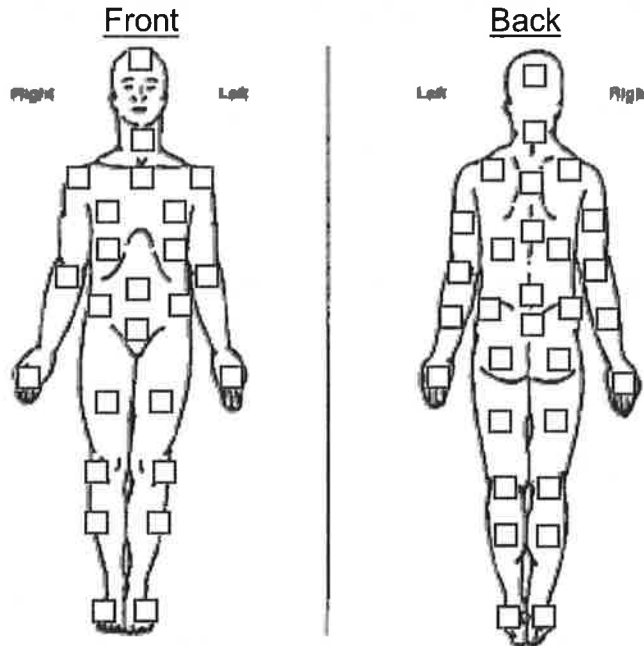
# Inventory (Short Form)

Developed by Charles S. Cleeland, PhD

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

Yes     No

2. On the diagram, check the areas where you feel pain.



3. Please rate your pain by marking the box beside the number that best describes your pain at its worst in the last 24 hours.

0     1     2     3     4     5     6     7     8     9     10  
No Pain    Pain As Bad As You Can Imagine

4. Please rate your pain by marking the box beside the number that best describes your pain at its least in the last 24 hours.

0     1     2     3     4     5     6     7     8     9     10  
No Pain    Pain As Bad As You Can Imagine

5. Please rate your pain by marking the box beside the number that best describes your pain on the average.

0     1     2     3     4     5     6     7     8     9     10  
No Pain    Pain As Bad As You Can Imagine

6. Please rate your pain by marking the box beside the number that tells how much pain you have right now.

0     1     2     3     4     5     6     7     8     9     10  
No Pain    Pain As Bad As You Can Imagine

**7. What treatments or medications are you receiving for your pain?**

**8. In the last 24 hours, how much relief have pain treatments or medications provided?**

**Please mark the box below the percentage that most shows how much relief you have received.**

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No Relief										Complete Relief

**9. Mark the box beside the number that describes how, during the past 24 hours, pain has interfered with your:**

**A. General Activity**

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Does Not Interfere										Completely Interferes

**B. Mood**

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Does Not Interfere										Completely Interferes

**C. Walking ability**

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Does Not Interfere										Completely Interferes

**D. Normal Work (includes both work outside the home and housework)**

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Does Not Interfere										Completely Interferes

**E. Relations with other people**

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Does Not Interfere										Completely Interferes

**F. Sleep**

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Does Not Interfere										Completely Interferes

**G. Enjoyment of life**

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Does Not Interfere										Completely Interferes



## Opioid Risk Tool(ORT)

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

Please mark each box that applies. Only complete the column that refers to **your gender**.

	Female	Male
<b>IS THERE A FAMILY HISTORY OF SUBSTANCE ABUSE</b>		
Alcohol	<input type="checkbox"/> 1	<input type="checkbox"/> 3
Illegal Drugs	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Prescription Drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4
<b>IS THERE A PERSONAL HISTORY OF SUBSTANCE ABUSE</b>		
Alcohol	<input type="checkbox"/> 3	<input type="checkbox"/> 3
Illegal Drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4
Prescription drugs	<input type="checkbox"/> 5	<input type="checkbox"/> 5
Age between 16-45 years	<input type="checkbox"/> 1	<input type="checkbox"/> 1
History of preadolescent Sexual abuse	<input type="checkbox"/> 3	<input type="checkbox"/> 0
<b>PSYCHOLOGICAL DISEASE</b>		
ADD, OCD, bipolar, schizophrenia	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Depression	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Scoring Totals		

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

