SHEVAYA WELLNESS

PATIENT INTAKE

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):

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

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 CareProvider

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)

☐ Gabapentin	☐ Lyrica	☐ Anti-Anxiety
☐ Antidepressants	☐ Muscle Relaxants	☐ Anti-inflammatories
☐ Narcotics/Opioids	☐ Methadone	☐ Lidocaine/Ketamine
☐ Nabilone	☐ Tramadol	☐ Sleep Medication
☐ 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 orwho 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 ALCOHOLHISTORY

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 perday? _____

Alcohol ☐ Yes ☐ No If yes, how many drinks perweek? _____

Have you ever been evaluated by another physician formedical marijuana? ☐ Yes ☐ No

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

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

How often do you usecannabis?

☐ 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 useit recreationally_____or for medicalreasons?_____

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 Questionaire

(G A D - 7)

Over the last 2 weeks, how often have you been bothered by the following problems? (Use "✔" to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
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____ = ____ + ____ + ____)

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Patient Health Questionaire

(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	☐0	☐1	☐2	☐3
2. Feeling down, depressed, or hopeless	☐0	☐1	☐2	☐3
3. Trouble falling or staying asleep, or sleeping too much	☐0	☐1	☐2	☐3
4. Feeling tired or having little energy	☐0	☐1	☐2	☐3
5. Poor appetite or overeating	☐0	☐1	☐2	☐3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐0	☐1	☐2	☐3
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐0	☐1	☐2	☐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 arounda lot more than usual	☐0	☐1	☐2	☐3
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐0	☐1	☐2	☐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**
☐	☐	☐	☐

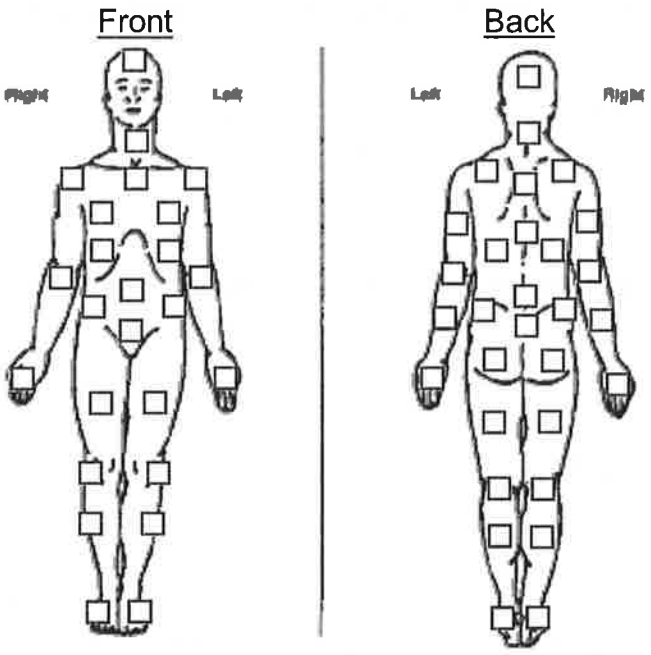
Inventory (Short Form)

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%
☐ 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

☐ 0 Does Not Interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely Interferes

B. Mood

☐ 0 Does Not Interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely Interferes

C. Walking ability

☐ 0 Does Not Interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely Interferes

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

☐ 0 Does Not Interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely Interferes

E. Relations with other people

☐ 0 Does Not Interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely Interferes

F. Sleep

☐ 0 Does Not Interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely Interferes

G. Enjoyment of life

☐ 0 Does Not Interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely Interferes

Opioid Risk Tool(ORT)

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

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

	Female	Male
IS THERE A FAMILY HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 1	☐ 3
Illegal Drugs	☐ 2	☐ 3
Prescription Drugs	☐ 4	☐ 4
IS THERE A PERSONAL HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 3	☐ 3
Illegal Drugs	☐ 4	☐ 4
Prescriptiondrugs	☐ 5	☐ 5
Age between 16 45 years	☐ 1	☐ 1
History of preadolescent Sexual abuse	☐ 3	☐ 0
PSYCHOLOGICDISEASE		
ADD, OCD, bipolar,schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
Scoring Totals		

Patient Signature:_____Date: _____