cannawellness
Tel (506) 470-6863
Fax (506) 454-7164
askus@cannawellness.ca

Patient Information Form

Name: _____ **DOB**: ___/___/_____
DD MM YYYY

Email: _____ **Phone #**: (_____) _____-_____

Address: _____

Medicare #: _____ Expiry Date: ___/___/_____

Marital Status: _____ **Children**: _____

Family Doctor (If none, please note): _____

Current Employment: _____

Family History (e.g.: Diabetes, depression, schizophrenia or other mental illnesses, heart disease, cancer, hypertension, kidney, or liver diseases, etc.): _____

_____

Past History (e.g. Surgeries, injuries, hospitalizations, and other medical diagnoses such as diabetes, depression, thyroid, heart problems, etc.): _____

Allergies (include medications, foods, and environmental triggers): _____

_____

Medications: Please list on reverse on page with dosages or attach a separate sheet from the pharmacy (please indicate past medications tried as well if possible).

Alcohol and Tobacco Intake (in an average day or week): _____

The purpose of the following information is to identify the status of your symptoms and then to monitor your response to treatment with medical cannabis over time.

Have you previously medicated with cannabis? If yes, indicate for how long: _____

What symptoms do you experience and how severe are they?

Please rate the following current symptoms from 0 to 10 (10 being the most severe). Use the line to the left to rate symptoms without the use of cannabis, and the line to the right to rate symptoms after use (leave right side blank if you have not yet medicated with cannabis).

_____	Anxiety	_____
_____	Hypervigilance	_____
_____	Depression	_____
_____	Anger and irritability	_____
_____	Poor concentration	_____
_____	Easily startled	_____
_____	Feeling disconnected from oneself or depersonalization	_____
_____	Suicidal thoughts	_____
_____	Avoidance of trigger related people and situations	_____
_____	Flashbacks and intrusive memories	_____
_____	Nightmares	_____
_____	Stuck in severe emotions related to the event	_____

Do you experience pain? Where is your pain located?

Please rate your average pain on a scale of 0 to 10 with 10 being the worst pain you have ever felt. The pain can be in a body part or outside of the body. Please draw a stick man to illustrate the pain, with a rating and an arrow pointing to the location.

What treatments have you tried and how effective have they been?

Please rate the following list from 0 to 10 (10 being very effective and 0 being none). Specify treatment on the line to the right when possible.

_____ Psychotherapy (e.g.: CBT/Exposure/Talk/EMDR) _____

_____ Relaxation therapy (e.g.: Meditation/Yoga) _____

_____ Nutrition therapy (including allergy testing) _____

_____ Exercise _____

_____ Nature (e.g.: Isolation/Hiking/Camping/Kayaking) _____

_____ Animals (e.g.: pets) _____

_____ Medications for your ailment _____

_____ Self-treatments with non-medical cannabis _____

_____ Time (it is resolving on its own with time) _____

How has your diagnosis impacted the following aspects of your life in recent months?

Please rate from 0 to 10 (10 being the most negative and 0 being neutral or unaffected).

_____ Drug and alcohol overuse

_____ Marital or relationship harmony

_____ Relationship with children

_____ Relationship with brothers / sisters / parents

_____ Belief that good things will happen in the future

_____ Feeling of belonging in the "human race" or your concepts of society

_____ Belief that you are a valuable and appreciated member of society

Cannabis has been surrounded by many stigmas in recent decades. Do you have any close family members or friends who you feel ***are not*** supportive of your cannabis therapy? Yes: ____ No: ____

Do you have any close family members or friends who you feel ***are*** supportive of your cannabis therapy? Yes: ____ No: ____

Information on Medical Cannabis

(1) The use of medical cannabis for various ailments is an off-label use of this substance. Even though there is growing evidence for its use, there is no consensus in the medical community for its use. Therefore, its use is intended in a situation where all conventional therapies have been tried and either found to be ineffective or have unacceptable side effects. (i.e.: as a last resort therapy)
(2) Risk of adverse health effects can be associated with smoking plant materials; it is recommended to use a vaporizer to avoid combustion.
(3) It is the patient's responsibility to report any serious adverse side effects and events to the prescribing physician, who in turn must report the event to Health Canada within 15 days of the event.
(4) The personal responsibility regarding medical cannabis is to ensure it is only used by the patient. It is not to be sold, shared, traded, or otherwise diverted away from its intended medical use. Care must be taken to avoid exposure of the cannabis products and fumes/vapor to any other persons.
(5) Any individual who has been recommended the use of medical cannabis may not have in their possession more than 30 times the daily amount, or a maximum of 150 grams of product (whichever is less).
(6) A deliberate breach of (4) and/or (5) is grounds for termination of access to medical cannabis.

Medical cannabis side effects and precautions: An extensive review of all side effects and precautions is available at the Health Canada website:
https://www.canada.ca/en/health-canada/services/drugs-health-products/medical-use-marijuana/information-medical-practitioners/information-health-care-professionals-cannabis-marihuana-marijuana-cannabinoids.html#chp50

Do you agree to follow up visits with the prescribing doctor to evaluate your response to the ongoing medical cannabis treatment? Yes: ____ No: ____

Do you agree to drug testing in the event it is requested? Yes: ____ No: ____

I understand the purpose for disclosing this personal health information. I authorize CannaWellness to share this information solely with the medical practitioner with whom my appointment is scheduled. I attest that all information I have provided in this form is accurate and true. I have read and understand this page.

My Name (Printed): _____ **Date:** ___/___/_____
DD MM YYYY

Signature: _____