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Experts in cannabis prescription
Les experts en prescription de cannabis

Medical Assessment and Intake Form

Personnal informations

First Name* : _____
Last Name : _____
Birth Date (m/d/y)* : _____
Health Card Number : _____
Email Adress* : _____
Home address* : _____
City* : _____ **Province* :** _____
Postal code : _____

How do you financially support yourself?

☐ Work ☐ Ontario Works ☐ ODSP ☐ Private Insurance

☐ CPP Disability ☐ Old Age Security ☐ Retired ☐ Support from other source

Do you need home assistance? ☐ Yes ☐ No

Medical informations

1. **Do you have a diagnosis given to you by physician or nurse practitioner or medical symptoms you've noticed (check all that apply) :**

☐Migraine	☐Diabetes	☐Ankylosing Spondylitis
☐Insomnia	☐Major Depression	☐Asthma
☐Rheumatoid Asthritis	☐IBS	☐Eating disorder
☐Crohn's	☐Ulcerative Arthritis	☐COPD
☐ADD/ADHD	☐Multiple Sclerosis	☐Menopause
☐Trigeminal Neuralgia	☐Bipolar Disorder	☐Muscle Spasm
☐Epilepsy	☐Fibromyalgia	☐Schizophrenia
☐Social Anxiety Disorder	☐Dysthymia	☐Lupus
☐MSK Strain / Sprain	☐Restless Legs Syndrome	☐Generalized Anciety Disorder
☐Degenerative Disc disease of Neck/Spine		☐Obstructive Sleep Apnea

☐Cancer (Please specify) : _____
☐Osteoarthritis (Please specify) : _____
☐Other : _____

2. **Have you had surgery?** ☐ Yes ☐ No
   If yes, please explain : _____

3. **What medication(s) do you take for your diagnose? Are you prescribed opiates for your current diagnosis?** (Please attach list if you don't have room) : _____
   _____

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4. **Do you suffer from side effects of your medication?** Please, list them. _____
   _____

5. **Have you ever been hospitalized for a mental illness? Including suicide attempt and/or ideation.** ☐ Yes ☐ No

6. **Are you currently on a methadone or suboxone program for opioid dépendance?** (This will not negatively impact your application) ☐ Yes ☐ No
   if yes : Dose?_____ Carries?_____

7. **Are you currently taking Nabilone or Cesamel?** (Synthetic THC) ☐ Yes ☐ No

8. **Do you smoke tobacco?** ☐ Yes ☐ No
   If you have quit, how long ago? _____

9. **Do you drink alcohol?** ☐ Yes ☐ No
   If yes, how many drinks per week? _____

10. **Do you exercise?** ☐ Yes ☐ No
    If yes, how many minutes per week? _____

11. **Are you pregnant?** ☐ Yes ☐ No
    Are you currently breastfeeding? ☐ Yes ☐ No

12. **Would you say you have a high level of function during the day? You are able to dress and feed yourself, you can take transit or drive, you can walk up a flight of stairs, walk more than one block without any difficulty. You are able to manage your finances.**
    ☐ Yes ☐ No

<u>Chronic Pain assessment</u>

If you do not experience chronic pain, continue to the next section.

1. **On a scale of 1 (least) to 10 (worst), rate your pain at it's worst in the past 24 hrs :**
   ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
2. **On a scale of 1 (least) to 10 (worst), rate your pain at it's least in the past 24 hrs :**
   ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
3. **On a scale of 1 (least) to 10 (worst), rate your pain on an average :**
   ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
4. **On a scale of 1 (least) to 10 (worst), rate your pain today :**
   ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
5. **In the past 24 hrs, rate percentage of relief you have gotten from your current pain management medications and / or techniques :**
   ☐10% ☐20% ☐30% ☐40% ☐50% ☐60% ☐70% ☐80% ☐90% ☐100%

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6. **On a scale of 1 (least) to 10 (worst), rate how much your pain has interfered with each subject in the past 24 hrs :**
   a. Mood and enjoyment of life :
   □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
   b. Mobility & General Activity
   □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
   c. Work, both paid and unpaid (ex. housework) :
   □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
   d. Sleep :
   □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

Additionnal Information

1. **Do you ever used cannabis?** ☐ Yes ☐ No
2. **Do you currently use cannabis?** ☐ Yes ☐ No
   If yes, how many per day? _____
3. **If using cannabis, is your physician aware that you are?** ☐ Yes ☐ No
4. **What was their reaction to you disclosing this?** _____
   _____
   _____
5. **How do you plan on using cannabis?** ☐Smoke ☐Vape ☐Ingestion (edibles)
6. **Have you researched using cannabis in your workplace?** ☐ Yes ☐ No
7. **Are you aware of the policy on cannabis use of their employees?** ☐ Yes ☐ No
8. **Have you ever been charged for drug trafficking?** ☐ Yes ☐ No
   Pending cases? ☐ Yes ☐ No

Please provide any additional information that may be relevant to your candidacy for medical cannabis : _____
_____
_____

Please attach any relevant medical history, scans / imaging and consults from other physicians or specialists.

Declaration / Release of Information

I, _____ hereby declare that the above medical information is true to the best of my knowledge and belief. Further I agree to authorize the release of any medical records to the physician or practitioner prescribing on begalf of PharmaCann Clinic telemedicine clinic to verify my medical condition(s).

Patients signature : _____ Date : _____