NATIONAL
CANNABINOID
CLINICS

Leaders in Patient-Centred Cannabinoid Medicine and Medical Marijuana Therapy

Date: ____________________

PATIENT INTAKE FORM

NAME: ____________________ AGE:______ GENDER: ______
TEL: ____________________ EMAIL: ____________________
ADDRESS: ____________________

FAMILY PHYSICIAN INFORMATION: NAME: ____________________
ADDRESS: ____________________
TEL: ____________________ FAX: ____________________

PRESENT COMPLAINT

WHAT IS YOUR MEDICAL CONDITION? ____________________
HOW LONG HAVE YOU HAD THIS CONDITION? ____________________
WHAT MAKES IT WORSE? ____________________
____
WHAT MAKES IT BETTER? ____________________
____
WHAT ACTIVITIES CAN YOU NO LONGER DO BY YOURSELF BECAUSE OF YOUR CONDITION? (eg. banking/groceries/laundry/bathing yourself)____________________
____

SYMPTOMS ASSOCIATED WITH YOUR PRIMARY CONDITION: (Level 1 = not severe, Level 5 = very severe)

	1	2	3	4	5
MUSCLE SPASM	☐	☐	☐	☐	☐
MOBILITY	☐	☐	☐	☐	☐
HEADACHE	☐	☐	☐	☐	☐
NAUSEA/VOMITING	☐	☐	☐	☐	☐
LOW ENERGY	☐	☐	☐	☐	☐
DIARRHEA	☐	☐	☐	☐	☐
CONSTIPATION	☐	☐	☐	☐	☐
ANXIETY	☐	☐	☐	☐	☐
DEPRESSION	☐	☐	☐	☐	☐
POOR CONCENTRATION	☐	☐	☐	☐	☐
DIFFICULTY SLEEPING	☐	☐	☐	☐	☐
WEIGHT LOSS	☐	☐	☐	☐	☐
LOSS OF APPETITE	☐	☐	☐	☐	☐

OTHER:
____

(office use)

CURRENT MEDICATIONS + DOSAGES:

____
____
____
____
____
____

MEDICATIONS USED IN THE PAST FOR YOUR CONDITION:

____
____
____
____
____
____

HAVE YOU HAD MEDICATION SIDE EFFECTS?
☐ NO ☐ YES, explain:____________________

ALLERGIES: ____________________

WHAT THERAPIES HAVE YOU TRIED?: (Level 1 = not effective, Level 5 = very effective)

	1	2	3	4	5
THERAPEUTIC INJECTIONS	☐	☐	☐	☐	☐
PHYSIOTHERAPY	☐	☐	☐	☐	☐
CHRIROPRACTIC	☐	☐	☐	☐	☐
MASSAGE	☐	☐	☐	☐	☐
ULTRASOUND	☐	☐	☐	☐	☐
ELECTRICAL STIMULATION	☐	☐	☐	☐	☐
LASER	☐	☐	☐	☐	☐
ACCUPUNCTURE	☐	☐	☐	☐	☐
PSYCHOTHERAPY	☐	☐	☐	☐	☐

OTHER: ____________________

(office use)

OTHER MEDICAL PROBLEMS (unrelated to today's visit)? (eg. high blood pressure, diabetes, etc.)

OPERATIONS :

PAST PSYCHIATRIC HISTORY:
HAVE YOU **EVER** SEEN A PSYCHIATRIST FOR A MENTAL HEALTH ISSUE?
☐ NO ☐ YES, MOST RECENT VISIT:
☐ within last month ☐ 1-6 months ago ☐ 6-12 months ago ☐ greater than 1 year ago
REASON FOR VISIT: ☐ ANXIETY ☐ DEPRESSION ☐ PSYCHOSIS
☐ SCHIZOPHRENIA ☐ SUBSTANCE ABUSE ☐ BIPOLAR
☐ OTHER: ____________________
HAVE YOU **EVER** BEEN HOSPITALIZED FOR A MENTAL HEALTH CONDITION?
☐ NO ☐ YES
DO YOU HAVE A BLOOD RELATIVE WITH A HISTORY OF MENTAL HEALTH CONDITION?
☐ NO ☐ PSYCHOSIS ☐ SCHIZOPHRENIA ☐ OTHER: ____________________

OPIOID SCREENING TOOL:
(circle the most relevant below answer, if "NO", then do not circle)

	FEMALES	MALES
Has anyone in your family had a history of substance abuse?		
YES – alcohol abuse	1	3
YES – illegal drug abuse	2	3
YES – Prescription drug abuse	4	4
Have you personally had a history of substance abuse?		
YES – alcohol abuse	3	3
YES – illegal drug abuse	4	4
YES – Prescription drug abuse	5	5
Are you between the ages of 16 and 45? YES	1	1
Do you have a history of preadolescent sexual abuse? YES	3	0
Have you ever been diagnosed with.....? (circle the diagnosis)		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1

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CANNABINOID HISTORY:

HAVE YOU USED MARIJUANA IN THE PAST? ☐ NO ☐ RECREATIONALLY ☐ MEDICALLY

HAVE YOU USED SYNTHETIC MARIJUANA? (eg Nabilone, Cesamet, etc.) ☐ NO ☐ YES

SIDE EFFECTS? ☐ "HIGH"/EUPHORIA ☐ DRY MOUTH ☐ INCREASED APPETITIE

HOW OFTEN DO YOU USE MARIJUANA?
☐ EVERY DAY ☐ 1-2 DAYS PER WEEK ☐ 3-4 DAYS PER WEEK ☐ 5-6 DAYS PER WEEK

HOW MANY GRAMS PER DAY?
☐ LESS THAN 1 GM/DAY ☐ 1-3 GM/DAY ☐ 3-5 GM/DAY ☐ MORE THAN 5GM/DAY

METHOD OF CONSUMPTION: ☐ SMOKE ☐ VAPE ☐ OILS ☐ EDIBLES ☐ LOTION

HOW LONG HAVE YOU BEEN USING MARIJUANA?
☐ LESS THAN 1 YEAR ☐ 1-3 YEARS ☐ 4-5 YEARS ☐ 6-10 YEARS ☐ 11-20 YEARS ☐ >20 YRS

IS CANNABIS YOUR MOST EFFECTIVE MEDICATION FOR YOUR CONDITION?
☐ NO ☐ YES

HAS MARIJUANA HELPED LOWER THE DOSE OF OTHER MEDICATIONS?
☐ NO ☐ YES, EXPLAIN: ____________________

HAVE YOU TAKEN A BREAK FROM USING MARIJUANA?
☐ NO ☐ YES
IF YES, WHAT HAPPENED? ____________________

DO YOU SMOKE? ☐ NO ☐ LESS THAN 1 PACK/DAY ☐ MORE THAN ONE PACK PER DAY
☐ QUIT (_________YEARS AGO)

HOW MUCH ALCOHOL DO YOU DRINK IN A WEEK? ☐ NONE
☐ OCCASIONALLY ☐ 1-3 PER WEEK ☐ 4-5 PER WEEK ☐ 5-7 PER WEEK ☐ MORE THAN 7

SOCIAL HISTORY:
MARITAL STATUS? ____________________
WHO LIVES AT HOME WITH YOU? ____________________
DO YOU HAVE CHILDREN? ____________________
HOW DO YOU FINANCIALLY SUPPORT YOURSELF?
☐ WORK, OCCUPATION: ____________________
☐ ODSP ☐ CPP DISABILITY ☐ OLD AGE SECURITY ☐ RETIRED ☐ PRIVATE INSURANCE
HOBBIES:

GOALS OF THERAPY:

RX:

F/U: