Referral Source

No.

Cannascribe
Medical Marijuana Prescription Service

PATIENT ASSESSMENT FORM

Date | Month | Day | Year

Patient Assessment Form

For Patients Seeking a Medical Cannabis Prescription

General Details

Patient's Name: First Name | Last Name

Health Card # | Skype:

Date of Birth: MM/DD/Year | Email:

Current Age: | Gender: Male: ◯ Female: ◯

If female, are you pregnant or nursing: Yes: ◯ No: ◯

Best time to contact:

Contact Information (if different from business location)

Address:

City: | Prov: | Postal:

Home: | Mobile:

General Practitioner Information:

Doctor's Name: First Name | Last Name

Date of Last Visit: Month | Day | Year

Reason for Last Visit:

Are you seeing a specialist: Yes: ◯ No: ◯

Specialist's Name: First Name | Last Name

Date of Last Visit: Month | Day | Year

Patient Assessment Form

For Patients Seeking a Medical Cannabis Prescription

Your Medical Condition and Symptoms

Primary Condition:

Check symptoms associated with your Primary Condition.

Indicate level of symptom severity. Level 1 - not severe. Level 5 - very severe

Pain:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Anxiety:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Nausea / Vomiting:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Muscle Spasms:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Depression:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Low Energy:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Mobility:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Concentration / Focus:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Diarrhea:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Headache:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Sleep Disturbance:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Constipation:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Seizures:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Visual Disturbance:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Medication Side Effects:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Involuntary Movements:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Weight Loss:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Other:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Medical History

How much does your condition affect your daily routine? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Indicate level of symptom severity. Level 1 - not severe. Level 5 - very severe

Comments:

How much does your condition affect your ability to work? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Indicate level of symptom severity. Level 1 - not severe. Level 5 - very severe

Comments:

Current Medications:
Please indicate dosage

Drug Allergies:

What therapies have you tried? Please check all that apply.

Indicate level of effectiveness — Not Effective (**NE**), Effective (**E**), Very Effective (**VE**).

	NE	E	VE	
Physiotherapy:	☐	☐	☐	Current Prescription:
Chiropractic:	☐	☐	☐	Indicate Dosage
Naturopathic/Homeopathic:	☐	☐	☐	
Counseling/Psychotherapy:	☐	☐	☐	
Therapeutic Injections:	☐	☐	☐	
Acupuncture:	☐	☐	☐	

Have you been diagnosed with any dependence on any drug, prescribed or otherwise? Yes: ◯ No: ◯

Have you previously used cannabis for symptom relief? Yes: ◯ No: ◯

Have you suffered from Psychotic Illness currently or in the past? Yes: ◯ No: ◯

Has a close member suffered from Psychotic Illness? Yes: ◯ No: ◯

Would you feel at risk using cannabis outside your current medical treatment? Yes: ◯ No: ◯

Do you suffer from heart disease? Yes: ◯ No: ◯

Patient Assessment Form

For Patients Seeking a Medical Cannabis Prescription

How much cannabis do you use per day?:

What is your preferred method of taking cannabis?

Inhalation / Smoke: ☐ Oral / Eat ☐ Topical / Cream ☐

What are your treatment goals?

Reduce Pain: ☐ Improve Daily Function: ☐ Improve Mood: ☐ Improve Appetite: ☐ Improve Sleep: ☐ Involuntary Movements: ☐

Why is cannabis appropriate as a medical treatment for you?

Signature

Name: First Name Last Name

Date signed: Month Day Year