Patients name:_______________________________________Date of Birth_____________________

Address: ____

Phone Number: cell________________________home:_____________________________________

Emergency Contact: ____

Gender:___________________________Ethnicity:____

Email:____

1. Do you have a severe cardiac condition? ◯ Yes ◯ No
2. Do you smoke tobacco? ◯ Yes ◯ No
   a. If yes, how often? QTY __________cigs per day/packs per day
3. Do you drink alcohol? ◯ Yes ◯ No
   a. If yes, how often? QTY __________daily/weekly/monthly
4. Do you use illicit drugs? ◯ Yes ◯ No
5. Do you have history of substance abuse? ◯ Yes ◯ No

   Please select the particular substance
   - Cocaine
   - Opioids
   - Alcohol
   - Other

   Have you abstained from using any substances of abuse for 5 years or more? Yes ◯ No ◯

   Are you currently on: ◯ Methadone Replacement Therapy ◯ Suboxone Replacement Therapy ◯ Alcohol Withdrawal Program ◯ Addictions Related Mental Health

6. Do you have any family history of psychosis? Yes ◯ No ◯ Unknown ◯
7. Do you have any family history of schizophrenia? Yes ◯ No ◯ Unknown ◯
8. Do you have any family history of cardiac conditions? Yes ◯ No ◯ Unknown ◯
9. Are planning on having a baby? ◯ Yes ◯ No

   Pregnant? ◯ Yes ◯ No

   Breastfeeding? ◯ Yes ◯ No

CANNACAREDOCS

PRIMARY CONDITION- PLEASE CHOOSE ONLY ONE

- ADD/ADHD
- Alzheimer's Disease
- ALS- Amyotrophic Lateral Sclerosis
- Anorexia
- Anxiety
- Appetite Stimulation
- Arthritis
- Autism
- Back & Neck problems
- Cachexia/Wasting Syndrome
- Cancer Related Pain
- Chemotherapy Induced Nausea
- Chronic Nausea
- Chronic Pain
- Colitis
- Crohns Disease
- Depression
- Dravet Syndrome
- Epilepsy
- Fibromyalgia
- Glaucoma
- Headaches
- Hepatitis C
- HIV/AIDS
- Insomnia
- Irritable Bowel Syndrome
- Migraines
- Mood Disorders
- Movement Disorder
- Multiple Sclerosis
- Muscle Spasm
- Neuropathic Pain
- Obesity
- Obsessive Compulsive Disorder
- Opiate Dependence
- Parkinson's
- PTSD
- Scoliosis
- Spinal cord Injury/disease
- Stress
- Tourette's Syndrome
- Tremors

Other ____

Please Select SECONDARY CONDTIONS (Select ALL that apply

- ADD/ADHD
- Alzheimer's Disease
- ALS- Amyotrophic Lateral Sclerosis
- Anorexia
- Anxiety
- Appetite Stimulation
- Arthritis
- Autism
- Back & Neck problems
- Cachexia/Wasting Syndrome
- Cancer Related Pain
- Chemotherapy Induced Nausea
- Chronic Nausea
- Chronic Pain
- Colitis
- Crohns Disease
- Depression
- Dravet Syndrome
- Epilepsy
- Fibromyalgia
- Glaucoma
- Headaches
- Hepatitis C
- HIV/AIDS
- Insomnia
- Irritable Bowel Syndrome
- Migraines
- Mood Disorders
- Movement Disorder
- Multiple Sclerosis
- Muscle Spasm
- Neuropathic Pain
- Obesity
- Obsessive Compulsive Disorder
- Opiate Dependence
- Parkinson's
- PTSD
- Scoliosis
- Spinal cord Injury/disease
- Stress
- Tourette's Syndrome
- Tremors

CANNACAREDOCS

Current Medications (include dose) ____

____

Previous Medications (include dose) ____

Therapies you have tried (indicate if past):

Therapy	Past	Therapy	Past
◯ Acudetox	☐ Past	◯ Homeopathic Medicine	☐ Past
◯ Acupuncture	☐ Past	◯ Massage Therapy	☐ Past
◯ Addictions Counseling	☐ Past	◯ Mental Health Counseling	☐ Past
◯ Aroma Therapy	☐ Past	◯ Mindful-Based Cognitive	☐ Past
◯ Chiropractor	☐ Past	◯ Naturopathic Medicine	☐ Past
◯ Cognitive Behavior	☐ Past	◯ Physiotherapy	☐ Past
◯ Exercise	☐ Past	◯ Reiki	☐ Past

Past Surgical History:____

Hospitalization/serious illness: ____

Allergies:____

What is the strain name of your cannabis?______________________ ◯ UNKNOWN

Are you currently using this strain? Yes ◯ No ◯ How often? __________daily/weekly/monthly

Average dosage __________ gram/mg/ml Strain profile: **THC** **CBD** **HYBRID** **NOT SURE**

Cannabinoid Profile Ratio (THC:CBD) ________:________ THC% ________ CBD% ________

Time of day Used:

◯ Morning ◯ Afternoon ◯ Evening ◯ Night

Mode of administration:

◯ Topical ◯ Oromucosal ◯ Vaporization ◯ Oil ◯ Smoking ◯ Edible

CANNACAREDOCS

Which of the **POSITIVE EFFECTS** have you experienced**?**

◯ Energetic ◯ Euphoric ◯ Improved Fatigue ◯ Improved Appetite
◯ Improved Mood ◯ Improved Sleep ◯ Improvement in Relations ◯ Increase in Mobility
◯ Increased Creativity ◯ Increased Focus ◯ Increased Motivation ◯ Increased Productivity
◯ Pain reduction ◯ Reduced Anxiety ◯ Reduced Bowel Movements ◯ Reduced Headache/Migraine
◯ Reduced Nausea ◯ Reduced seizure activity ◯ Reduced Stress ◯ Reduced Vomiting
◯ Relaxed ◯ Uplifted
◯ Other ____

Notes: ____

Which of the following **NEGATIVE** side effects have you experienced**?**

◯ Dizziness ◯ Drowsiness ◯ Dry Eyes ◯ Dry Mouth
◯ Fatigue ◯ Headache ◯ Increased Anxiety ◯ Increased Appetite
◯ Increased Heart Rate ◯ Memory Loss ◯ Paranoia ◯ Red Eyes
◯ Other:____

Notes:____

How did you hear about Canna Care Docs? Check ALL that apply, we'd like to thank them.

◯ Google ◯ Newspaper ◯ TV news ◯ Facebook ◯ Friend
◯ Leafly ◯ Weedmaps ◯ Marijuana Docs
◯ Flyer – from where?____
◯ Referral – From whom?____

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities. If you are unsure how to answer a question, please give the best answer you can.

1. In general, how would you say your health is?

   Poor | Fair | Good | Very Good | Excellent

2. On a typical day, does your health limit you in the following activities?
   Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.

   None (Does not limit at all) | Yes, limit a little | Yes, limit a lot

   Climbing several flights of stairs.

   None (Does not limit at all) | Yes, limit a little | Yes, limit a lot

3. Over the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
   Accomplished less than you would like

   No | Yes

   Were limited in certain kinds of work/activities

   No | Yes

4. Over the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of emotional problems (such as feeling depressed or anxious)?
   Accomplished less than you would like

   No | Yes

   Did work or activities less carefully than usual

   No | Yes

5. Over the past 4 weeks, how much did pain interfere with your work (including outdoor and housework)?

Not at all | A little bit | Moderately | Quite a bit | Extremely

6. Considering the past 4 weeks, please give the answer that comes closest to the way you have been feeling:

Calm and peaceful

None of time | A little of the time | Some of the time | Most of the time | All of the time

A lot of energy

None of time | A little of the time | Some of the time | Most of the time | All of the time

Downhearted and blue

None of time | A little of the time | Some of the time | Most of the time | All of the time

7. Over the past 4 weeks, how much of the time has your physical health or emotional problems interfere with your social activities (like visiting friends/relatives, etc)

None of time | A little of the time | Some of the time | Most of the time | All of the time