Canna Care Docs

Patients name:____

Address: ____

Phone Number:____

Emergency Contact: ____

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?____

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 (non-cannabis)? Yes ◯ No ◯
5. Do you have history of drug abuse? Yes ◯ No ◯
   a. Please select the particular substance
      - Cocaine
      - Heroin
      - MDMA
      - Other

   b. 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 Management Program
      - Addictions Related Mental Health Counseling
6. Do you have any family history of psychosis? Yes ◯ No ◯
7. Do you have any family history of schizophrenia? Yes ◯ No ◯
8. Do you have any family history of cardiac conditions? Yes ◯ No ◯
9. Are planning on having a baby? Yes ◯ No ◯
10. Pregnant? ◯ Yes ◯ No Breastfeeding? Yes ◯ No ◯

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Primary conditions: Please select ONE PRIMARY CONDITION

◯ ADD/ADHD	◯ Alzheimer's Disease	◯ Anorexia
◯ Anxiety	◯ Appetite Stimulation	◯ Arthritis
◯ 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
◯ Parkinsons	◯ PTSD	◯ Scoliosis
◯ Spinal cord Injury/disease	◯ Stress	◯ Tremors

◯ Other ____

Please Select SECONDARY CONDTIONS (Select ALL that apply)

◯ ADD/ADHD	◯ Alzheimer's Disease	◯ Anorexia
◯ Anxiety	◯ Appetite Stimulation	◯ Arthritis
◯ 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
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◯ Spinal cord Injury/disease	◯ Stress	◯ Tremors

◯ Other ____

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Current Medications (include dose) _________________________ ___________________

_________________________ _________________________ ___________________

Previous Medications (include dose) _________________________ _________________

Therapies you have tried (indicate if past):

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

Past Surgical History:____

____

Hospitalization/serious illness: ____

____

Allergies:____

GAD (Generalized Anxiety Disorder)

Over the last two weeks, how often have you been bothered by the following problems:

	Not At All	Several Days	Over ½ days	Everyday
1. Feeling nervous, anxious or on edge	_______	________	_________	________
2. Not being able to stop or control worrying	_______	________	_________	_______
3. Worrying too much about things	_______	________	_________	_______
4. Trouble relaxing	_______	________	_________	_______
5. Being so restless that it's hard to sit still	_______	_______	_________	_______
6. Becoming easily annoyed or irritable	_______	________	_________	_______
7. Feeling afraid as if something awful might happen	_______	________	_________	_______

If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with people?

◯ Not difficult at all ◯ Somewhat difficult ◯ Very difficult ◯ Extremely difficult

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Do you have cannabis experience? Yes ◯ No ◯

Average dosage ______________________ gram/day mg/day ml/day

Cannabinoid Profile Ratio (THC:CBD) ___________________:___________________

Past usage:

◯ Daily ◯ Weekly ◯ Monthly ◯ Past Use

Time of day Used:

◯ Morning ◯ Afternoon ◯ Evening ◯ Night

Mode of administration:

◯ Topical ◯ Inhalation ◯ Oral ◯ Oromucosal

Which of the POSITIVE EFFECTS have you experienced?

◯Energetic ◯Euphoric ◯ Improved Appetite

◯Improved Fatigue ◯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:____