Medical Cannabis Patient Intake

First Name: _____ Surname: _____

Occupation *: _____

Please check the medical condition(s)/problem(s) that you are seeking medical cannabis treatment. (Please tick all that apply)

PSYCHIATRY

Psychiatry conditions

- [ ] ADD/ADHD symptoms
- [ ] Anxiety
- [ ] Eating Disorders
- [ ] Depression
- [ ] PTSD

NEUROLOGICAL

Neurological conditions

- [ ] Alzheimer's Disease
- [ ] Migraines
- [ ] Nerve Pain
- [ ] Essential Tremors
- [ ] Parkinson's Disease
- [ ] Other (discuss below)
- [ ] Epilepsy/Seizures
- [ ] Muscle Spasms/Spasticity
- [ ] Traumatic Brain Injury
- [ ] Multiple Sclerosis
- [ ] Spinal Cord Injury/Disease

CANCER

Cancer conditions

- [ ] Cancer (specify below)
- [ ] Chemotherapy side effects

PAIN

Pain conditions

- [ ] Arthritis
- [ ] Back and Neck Pain
- [ ] Post Operative Surgery Pain
- [ ] Repetitive Strain Injury
- [ ] Pelvic Pain
- [ ] Complex Regional Pain Syndrome
- [ ] Other (discuss below)

GASTRO

Gastro conditions

- [ ] Colitis
- [ ] Irritable Bowel Syndrome
- [ ] Crohn's Disease

OTHER DISORDERS

Other disorders

- [ ] Appetite
- [ ] Chronic Fatigue Syndrome
- [ ] HIV / AIDS symptoms
- [ ] Nausea
- [ ] Fibromyalgia
- [ ] Menopausal symptoms
- [ ] Sleep Disorders
- [ ] Other (discuss below)

If you'd like to give more details of your symptoms or have clicked other above, please specify;

Treating Specialist Name: _____

MEDICATION HISTORY

Have you tried at least two medicines or therapies to help treat the condition/s you've ticked above?

◯ Yes ◯ No

If yes, please list the medicines or therapies you have tried.

Please list your current prescribed medication

BASELINE HEALTH SCORES

Pain Score *

◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯

1 - rare pain 2 3 4 5 - moderate constant pain 6 7 8 9 10 - severe constant pain

Sleep Score *

◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯

1 - I sleep soundly 2 3 4 5 - sometimes I find it difficult to get to sleep 6 7 8 9 10 - severe insomnia

Mood Score *

◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯

1 - I feel happy all the time 2 3 4 5 - I sometimes feel sad 6 7 8 9 10 - I feel sad all the time

Anxiety Score *

◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯

1 - I am rarely anxious 2 3 4 5 - I am sometimes anxious 6 7 8 9 10 - I am anxious all the time

Quality of Life *

◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯

1 - I can do everything I want to 2 3 4 5 - I can't do most things I want to 6 7 8 9 10 - I can't do all things I want to

Do you have a history of heart problems including palpitations, heart attack (MI), stroke, angina, chest pain, shortness of breath, arrhythmias (irregular heart beats), pacemaker, or taking any heart medications? If yes, specify below;

◯ No ◯ Yes

Are you currently being treated for cancer or undergoing any cancer treatments? If yes, specify below;

◯ No ◯ Yes

Do you have any history of liver disease including hepatitis, elevated liver enzyme function blood tests, fatty liver cirrhosis? If yes, specify below;

◯ No ◯ Yes

Female patient only: Are you currently pregnant?

◯ No ◯ Yes

If you answered 'Yes' above - please specify;

PSYCHIATRIC HISTORY

Have you ever had?

- ☐ Mania (bipolar disorder)
- ☐ Schizophrenia
- ☐ Depression
- ☐ PTSD
- ☐ Personality Disorder
- ☐ Generalised Anxiety Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Are you currently or previously suicidal

Other

Have you ever been referred to a psychiatrist or to a community mental health service?

◯ No ◯ Yes

FAMILY HISTORY:

Does anyone in your immediate family suffer from any of the following conditions?

Please tick all that apply

- ☐ Psychosis
- ☐ Schizophrenia
- ☐ Depression
- ☐ Bipolar/Manic Depression/Mania

If so what is their relation to you? (ie. parent/sibling/cousin/uncle/aunt/child):

DRUG AND ALCOHOL HISTORY

Do you have any personal history of drug abuse or dependency such as: heroin, cocaine, LSD, marijuana, ecstasy, GHB, legal highs such as spice, prescription drug abuse (such as opioids, painkillers or benzodiazepines)? If yes specify;

- ◯ No
- ◯ Yes

Do you have a history of alcohol abuse or dependency?

- ◯ No
- ◯ Yes

CANNABIS HISTORY

- ☐ I understand that The Medical Cannabis Clinics have a partner pharmacy called Dispensary Green *
- ☐ I understand that I have the right to use any other specialist pharmacy *

Do you already use cannabis?

- ◯ No
- ◯ Yes

If you do use cannabis currently, how often do you use cannabis?

- ◯ Everyday
- ◯ Every other day
- ◯ 1-2 times per week
- ◯ Never

How much cannabis do you currently use per day? (Ie number of ounces, grams or joints per day)

How have you used cannabis?

- ☐ Smoking
- ☐ Vaporizing
- ☐ Ingestion
- ☐ Topical

What strains have you used? (Check all that apply)

- ☐ Indica
- ☐ Sativa
- ☐ Hybrid
- ☐ All

What names of strains have you used (if known?) ie 'OG Shark, pink kush, etc'

If known, which strains/names have you found most useful for which symptom? (Ie OG shark for headache or Indica for night pain etc)

Have you had any serious reaction to cannabis?

If you have tried cannabis for your symptoms in the past but stopped, why did you stop cannabis?

Current over the counter supplements (including details of any over the counter CBD oils/products if applicable)

Allergies (please list all allergies)

Please provide any medical history you have relating to your medical condition/s. For example, specialist / clinical letters, therapy appointments, private prescriptions, medication history. We require as much medical history for our specialist team to review ahead of your consultation to check you are eligible for medical cannabis treatment. This information will also be extremely helpful for the consultant to better understand your needs. Please forward these documents at your earliest convenience to soc@themcclinics.com to avoid delay in your consultation.

NEXT OF KIN

Name *: _____ Contact Phone Number *: _____

☐ I give permission for my Next of Kin to speak to The Medical Cannabis Clinics on my behalf

In order to get the most out of your consultation with the Specialist, please outline any expectations you may have for your appointment.

PATIENT DECLARATION

☐ By clicking Yes; I confirm that the information provided in this medical questionnaire is correct and complete to the best of my knowledge. I understand that the The Medical Cannabis Clinics may share my information with an affiliated doctor if best suited to my condition. I understand that my GP will be notified of my appointment to ensure continuity of my care. I understand that failure to provide true and correct information could result in my prescribed medical cannabis being withdrawn by the prescribing specialist. *