



J/W Mariceuticals Inc.

Natural Choices / Healthy Options



Cannascribe
Medical Marijuana Prescription Service

No.



PATIENT ASSESSMENT FORM

Date

Month

Day

Year

Patient Assessment Form

For Patients Seeking a Medical Cannabis Prescription

General Details

Patient's Name:

Health Card # Skype:

Date of Birth: 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:

Date of Last Visit:

Reason for Last Visit:

Are you seeing a specialist: Yes: No:

Specialist's Name:

Date of Last Visit:

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:	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	Anxiety:	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	Nausea / Vomiting:	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
Muscle Spasms:	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	Depression:	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	Low Energy:	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
Mobility:	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	Concentration / Focus:	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	Diarrhea:	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
Headache:	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	Sleep Disturbance:	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	Constipation:	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
Seizures:	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	Visual Disturbance:	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	Medication Side Effects:	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
Involuntary Movements:	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	Weight Loss:	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	Other: _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current Prescription:
Chiropractic:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indicate Dosage
Naturopathic/Homeopathic:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Counseling/Psychotherapy:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Therapeutic Injections:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Acupuncture:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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:

Date signed:

