PATIENT ASSESSMENT FORM

Simcoe Holistic HEALTH

Date

Month Day Year

Patient Assessment Form

For Patients Seeking a Medical Marijuana Perscription

General Details

First Name		D.O.B.	Day	Month	Year
Last Name		Gender	Male ☐	Female ☐	Current Age
Health Card #		If female, are you pregnant or nursing?	Yes ☐	No ☐	
Height		Weight			

Contact Information

City		Home Phone		Skype Name	
Street		Cell Phone			
Postal Code		Email			

General Practioner Information

Name of Doctor		Are you seeing a specialist?	Yes ☐	No ☐
Date of last visit		Specialist Name		
Reason for visit		Date of last visit		

Additional Notes

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Your Medical Condition & Symptoms

Primary Condition

Check off symptoms associated with your primary condition. Check level of symptom serverity
1 - not severe
5 - very severe

Pain	☐1 ☐2 ☐3 ☐4 ☐5	Sleep disturbance	☐1 ☐2 ☐3 ☐4 ☐5
Muscle spasms	☐1 ☐2 ☐3 ☐4 ☐5	Visual disturbance	☐1 ☐2 ☐3 ☐4 ☐5
Mobility	☐1 ☐2 ☐3 ☐4 ☐5	Weight loss	☐1 ☐2 ☐3 ☐4 ☐5
Headache	☐1 ☐2 ☐3 ☐4 ☐5	Lack of appetite	☐1 ☐2 ☐3 ☐4 ☐5
Seizures	☐1 ☐2 ☐3 ☐4 ☐5	Nausea/vomiting	☐1 ☐2 ☐3 ☐4 ☐5
Involuntary movements	☐1 ☐2 ☐3 ☐4 ☐5	Low energy	☐1 ☐2 ☐3 ☐4 ☐5
Anxiety	☐1 ☐2 ☐3 ☐4 ☐5	Diarrhea	☐1 ☐2 ☐3 ☐4 ☐5
Depression	☐1 ☐2 ☐3 ☐4 ☐5	Constipation	☐1 ☐2 ☐3 ☐4 ☐5
Concentration/Focus	☐1 ☐2 ☐3 ☐4 ☐5	Med. Side effects	☐1 ☐2 ☐3 ☐4 ☐5
		Other:_____	☐1 ☐2 ☐3 ☐4 ☐5

Medical History

How much does your condition affect your daily routine? Check level of symptom serverity 1 - not severe 5 - very severe	☐1 ☐2 ☐3 ☐4 ☐5 **Comments:**	How much does your condition affect your ability to work? Check level of symptom serverity 1 - not severe 5 - very severe	☐1 ☐2 ☐3 ☐4 ☐5 **Comments:**
Current medications Please indicate the Dosage	**Medication:** **Medication:** **Medication:**		

Drug Allergies

What therapist have you tried? Check all that apply and level of symptom serverity 1 - not severe 5 - very severe	Physiotherapy ☐1 ☐2 ☐3 ☐4 ☐5 Chiropractic ☐1 ☐2 ☐3 ☐4 ☐5 Naturopathic/Homepathic ☐1 ☐2 ☐3 ☐4 ☐5 Counselling/Psychotherapy ☐1 ☐2 ☐3 ☐4 ☐5 Theraputic Injections ☐1 ☐2 ☐3 ☐4 ☐5 Acupuncture ☐1 ☐2 ☐3 ☐4 ☐5	Current prescription Medication (please indicate dosage)	_____ ☐1 ☐2 ☐3 ☐4 ☐5 _____ ☐1 ☐2 ☐3 ☐4 ☐5 _____ ☐1 ☐2 ☐3 ☐4 ☐5 _____ ☐1 ☐2 ☐3 ☐4 ☐5 _____ ☐1 ☐2 ☐3 ☐4 ☐5 _____ ☐1 ☐2 ☐3 ☐4 ☐5

Have you had a history with substance abuse?	Yes ☐ No ☐	Would you feel at risk taking cannabis without or in conjunction with your current medication?	Yes ☐ No ☐	Have you suffered From a Psychotic Illness in the past Or currently?	Yes ☐ No ☐	Have you previously Used cannabis for Symptom relief	Yes ☐ No ☐
Has a close family member Suffered from Psychotic illness?	Yes ☐ No ☐	Do you suffer from Heart disease?	Yes ☐ No ☐	Have you ever been Prescribed Synthetic cannabis?	Yes ☐ No ☐		

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Medical History Continued

How much cannabis do You use per day?				
What is your preferred method for ingesting cannabis?	Inhalation/Smoke ☐ Oral/eat ☐ Topical / cream ☐	Preferred tools for ingesting cannabis? Vaporizor ☐ WaterPipe ☐ Rolling Paper ☐	What are your Treatment goals?	Reduce Pain ☐ Improve daily function ☐ Improve appetite ☐ Improve mood ☐ Improve sleep ☐ Other_____
Why is cannabis Appropriate as a medical Treatment for you?				

Signature	
Full Name	
Date Signed	Day / Month / Year