

Medical condition(s) for which marijuana use is being considered? \_\_\_\_\_

Could you provide medical records to prove you have this condition?

YES ☐

NO ☐

Have you been able to find a Medical Marijuana physician in your province/territory?

YES ☐

NO ☐

Has your quality of life been adversely effected by the symptoms of your medical condition(s)?

YES ☐

NO ☐

Have the symptoms of your medical condition(s) persisted despite traditional treatments?

YES ☐

NO ☐

N/A ☐

Have you ever had side effects from traditional treatments like surgery or pharmaceuticals?

YES ☐

NO ☐

Do you feel that Medical Marijuana may be appropriate for your health condition(s)?

YES ☐

NO ☐

Have you ever used marijuana before? YES ☐ NO ☐

Was it helpful for your medical problem(s) you outlined above?

YES ☐

NO ☐

N/A ☐

How did you use marijuana? Inhaled ☐ Orally ☐ Other ☐ (spray, tincture, ointment)

Negative side effects? YES ☐ NO ☐

Are you legally able to make all healthcare decisions on your own without the permission of anyone else? YES ☐ NO ☐

Do you agree to be monitored by your physician/primary care provider via regular check-ups? (Prescription medications may need to be adjusted) YES ☐ NO ☐

Do you agree to be monitored by PharmaNet or a similar pharmacy medication data base in your province? (Prescription medications may interact with marijuana)

YES ☐

NO ☐

Might you be interested in participating in a future confidential clinical study?

YES ☐

NO ☐

\_\_\_\_\_  
(Name of Client)

\_\_\_\_\_  
(Signature of Client)

\_\_\_\_\_  
(Date)  
Revised November 2014