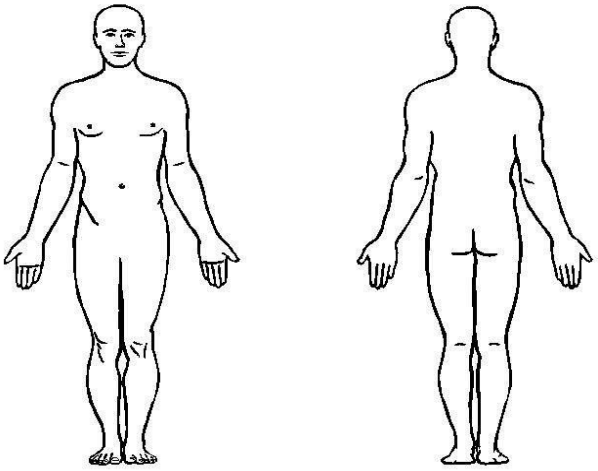
Name: _____
Date: _____

Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains and toothaches). Have you had pain other than these everyday kinds of pain today?

Yes No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its **worst** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its **least** in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on **average**.

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

6. Please rate your pain by circling the one number that best describes how much pain you have **right now**.

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

7. In the past 24 hours, how much relief have you pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0% 10 20 30 40 50 60 70 80 90 100%
No Relief Complete Relief

8. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A) General Activity
0 1 2 3 4 5 6 7 8 9 10
Not at all Greatly Interferes

B) Mood
0 1 2 3 4 5 6 7 8 9 10
Not at all Greatly Interferes

C) Walking Ability
0 1 2 3 4 5 6 7 8 9 10
Not at all Greatly Interferes

D) Normal Work (Includes both work outside/home/housework)
0 1 2 3 4 5 6 7 8 9 10
Not at all Greatly Interferes

E) Relations with other people
0 1 2 3 4 5 6 7 8 9 10
Not at all Greatly Interferes

F) Sleep
0 1 2 3 4 5 6 7 8 9 10
Not at all Greatly Interferes

G) Enjoyment of life
0 1 2 3 4 5 6 7 8 9 10
Not at all Greatly Interferes

H) Ability to concentrate
0 1 2 3 4 5 6 7 8 9 10
Not at all Greatly Interferes

I) Appetite
0 1 2 3 4 5 6 7 8 9 10
Not at all Greatly Interferes

9. In the area where you have pain, do you have “pins and needles”, tingling or prickling sensations?

Yes No

10. Does the painful area change colour (perhaps mottled or red) when the pain is particularly bad?

Yes No

11. Does your pain make the affected skin abnormally sensitive to the touch?

Yes No

12. Does your pain come on suddenly and in bursts for no apparent reason when you are completely still?

Yes No

13. In the area where you have pain, does your skin feel unusually hot like burning pain?

Yes No

14. Gently rub the painful area with your index finger and then rub a non-painful area. How does the rubbing feel in the painful area?

No Difference Discomfort

15. Gently press on the painful area with your fingertip then gently press in the same way to a non painful area. How does this feel in the painful area

No Difference Discomfort

Cannabis Questionnaire

1. List all medical issues, including ones you are not planning to treat with cannabis.

_____

_____

_____

_____

2. List all surgeries:

_____

_____

_____

_____

3. List all of your medications including herbals/vitamins/supplements (anything you take even without a prescription) and the dosage:

_____

_____

_____

4. List all allergies:

_____

_____

_____

5. Do you currently use cannabis? ( ) Yes ( ) No

If yes, how much?

_____

_____

_____

_____

6. How often do you use cannabis?

_____

_____

7. How effective is cannabis for your medical condition?

( ) Very Effective ( ) Effective ( ) Only somewhat effective

8. Have you ever had a medical cannabis prescription before? ( ) Yes ( ) No

If yes, when: _____

9. Do you have or have you ever had any of the following medical conditions:

( ) Asthma/Lung Disease ( ) Hepatitis ( ) Stroke ( ) Kidney Disease ( ) Thyroid ( ) Heart Disease ( ) Cancer ( ) ADD/ADHD ( ) Substance Abuse ( ) Depression ( ) MS ( ) Schizophrenia ( ) Hyper Tension

10. Do you currently use tobacco? ( ) No ( ) Yes. How much per week? _____

Canadian Cannabis Rx Consultants

Release, Acknowledgment & Indemnity for Patients Seeking an ACMPR Medical Document

I _____ understand that this release and acknowledgment contains valuable information about possessing/cultivating and consuming prescribed medical cannabis, that the assessing regulations (ACMPR). I also understand that the consulting specialist/physician will not necessarily be assuming primary care for me, but only be recognized as my ACMPR prescribing practitioner. I understand and agree to continue to regularly see my primary care physician for my medical conditions on a regular basis and notify them of my medical use of cannabis.

The specialist/physician will weigh the risks versus the rewards in treating my medical condition(s) and their symptoms associated, with medical cannabis. I confirm that the assessing specialist/physician will be the only practitioner providing a medical document under the ACMPR for the purpose of possessing/cultivating and consuming medical cannabis.
I agree to make no claims or commence any legal action against the assessing specialist/physician, my family physician or any other involved physicians in regards to:
a) My consumption of medical cannabis
b) My application or medical document(s) for possessing, obtaining, cultivating and consuming medical cannabis.

I am aware that specialists/physicians generally agree with medical cannabis:
-May affect sight, sounds and touch
-May impair thinking, problem-solving, coordination, memory and learning
-May increase heart rate and reduce blood pressure
-May induce anxiety, fear, distrust or panic
INITIAL _____

I am aware that medical conditions such as schizophrenia, atrial fibrillation, heart attack/stroke or use of blood thinners may results in a denial for my application to process and consume medical cannabis. I

am also aware that if pregnant or planning to become pregnant that medical cannabis should not be consumed during pregnancy or while breastfeeding.
INITIAL _____

FOR PATIENTS Pursuing an ACMPR Medical Document

I am aware of the considerable debate and lack of consensus among specialists and physicians about;
-The appropriate dose and medical use of cannabis
-The risks of burning medical cannabis as compared to vaporizing or ingesting
-The risks of burning extracted cannabinoids such as oils or hashish
-The long term psychological and health risks associated with medical cannabis
-The risk of pulmonary infections and respiratory cancer
-The risk of triggering mental illness, such as bipolar disorder or schizophrenia
-The risk of nausea and disorientation
-I agree not to sell, give away, or distribute in any way the cannabis grown under this license.
INITIAL _____

I _____ consent to the disclosure and sharing and use of my personal information and personal health information by the assessing specialist/physician, Canadian Cannabis Rx Consultants and my licensed producer. The information may be used to contact and register the patient. The information may also be used for analytical and research purposes.
INITIAL _____

I _____ truly believe that treating my personal medical condition(s) with medical cannabis potentially or has had a positive effect and the benefits outweigh the risks associated.
INITIAL_____

This is my personal decision to possess and consume medical cannabis and I do not support any claims made by family, friends, or other individuals against Canadian Cannabis Rx. Consultants or the prescribing specialists/physicians.
INITIAL_____

I hereby release Canadian Cannabis Rx Consultants, the assessing specialist/physician, from any and all claims, actions, causes of actions, complaints (including friends and family) and demands for damages, loss or injury arising directly or indirectly to my use of medical cannabis and my Application to possess, cultivate or consume medical cannabis.
INITIAL_____

This release from liability is to be binding on heirs, executors and signs and I acknowledge that I have the right to refuse to sign this form.
INITIAL_____

PRINT NAME: _____
SIGNATURE: _____
DATE SIGNED: _____
WITNESS PRINT NAME: _____
SIGNATURE: _____
DATE SIGNED: _____

Consent to Disclose Personal Health and Documentation

I, _____, give full authorization to Canadian Cannabis Rx Consultants to release, disclose and convey all

- medical records and information about me in your possession to discuss with Health Canada pertaining to verification of my ACMPR documentation.

I understand the purpose for disclosing this personal health information to Health Canada is to facilitate the process of my ACMPR registration.

My name: _____

Address: _____

Home Tel:_____

Work Tel: _____

Email Address: _____

Skype Username: _____ (This is REQUIRED for your appointment)

Signature: _____

Date: _____

Witness Name: _____

Address: _____

Home Tel:_____

Work Tel: _____

Signature: _____

Date: _____