BC WELLNESS CENTRE

203-518 Lake St.
Nelson, B.C. V1L 4C6
risebc.com

P: 250.352.5259
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MEDICAL CANNABIS INTAKE QUESTIONNAIRE

Name:

Are you an existing Medical Cannabis patient? Yes ☐ No ☐

Do you currently have another cannabis script from another physician? Yes ☐ No ☐

Please list which conditions you are seeking a cannabis prescription for:

List other medication/drugs/herbals you use(d):

Cannabis Use History:

Have you ever been evaluated by another physician for medical cannabis? Yes ☐ No ☐

If yes: When:

Where:

Do you use cannabis to reduce or eliminate the use of medication that have been prescribed to you for your medical condition? Yes ☐ No ☐

If yes, which medication have you reduced or eliminated and why:

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How effective is using cannabis for your medical problem?

Very Effective ☐ Effective ☐ Only Somewhat Effective ☐

How does cannabis affect you? How does it make you feel?

Do you regularly experience any unpleasant/unwanted side effects of marijuana use? Yes ☐ No ☐

If yes, please explain:

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Generalized Anxiety Disorder 7-item (GAD-7) Scale

Over the last two weeks how often have you been bothered by any of the following problems (check the applicable box & total below)	Not at all sure (0)	Several Days (1)	More than half the days (2)	Nearly every day (3)
1. Feeling nervous, anxious or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it's hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				
Totals				

Total Score = _____

If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? Put a checkmark beside the applicable level:

- Not Difficult at all ☐
- Somewhat Difficult ☐
- Very Difficult ☐
- Extremely Difficult ☐

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Patient Health Questionnaire – 9 (PHQ-9)

Over the last two weeks how often have you been bothered by any of the following problems (check the applicable box & total below)	Not at all sure (0)	Several Days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Trouble falling or staying asleep				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself, or that you are a failure or have let yourself down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed or the opposite- being so fidgety or restless that you may be moving around a lot more than usual				
9. Thoughts that you would be better off dead or thoughts of hurting yourself in some way				
Totals				

Total Score = _____

If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? Put a checkmark beside the applicable level:

- Not Difficult at all ☐
- Somewhat Difficult ☐
- Very Difficult ☐
- Extremely Difficult ☐

Submit