



MEDICAL CANNABIS ASSESSMENT: PATIENT SCREENING FORM

SOLACE HEALTH NETWORK

PATIENT INFO

Gender: Male Female Other

First Name: _____ Last Name: _____

Date of Birth: (dd/mm/yy) _____ Email: _____

Phone: _____ Can a voice message be left at this number? Yes No

Address: _____ Suite No.: _____

City: _____ Province: _____ Postal Code: _____

Caregiver Name: (if applicable) _____

REASON FOR SEEKING MEDICAL CANNABIS

- | | | |
|--|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Obsessive-Compulsive Disorder |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> HIV/aids Related Pain | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Post-Traumatic Stress Disorder |
| <input type="checkbox"/> Brain Injury E.G. Post-Concussion | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer Related Pain | <input type="checkbox"/> Lymes Disease | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Musculoskeletal Pain | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Myofascial Pain | |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Neuropathy | |

OTHER

DO YOU EXPERIENCE ANY OF THE FOLLOWING:

- | | |
|---|--|
| <input type="checkbox"/> Unstable Heart Disease | <input type="checkbox"/> Previous or Current Mental Health Condition |
| <input type="checkbox"/> Breastfeeding | <input type="checkbox"/> Previous or Current Drug or Alcohol Abuse |
| <input type="checkbox"/> Pregnant or Trying to Conceive | |

Patient/Caregiver Signature: _____ Date: (dd/mm/yy) _____

Patient/Caregiver: I acknowledge that the information above is true. I also acknowledge that I have expressed interest in exploring medical cannabis as a treatment option. All information is kept as per our privacy policy available at terrahealthnetwork.com

I acknowledge and confirm that by submitting the Screening Tool and/or Enrolment Form that I may be contacted by Solace Health Network's Service Providers, or affiliates of Solace Health Network including Solace Health Inc. and TerraAscend Corp., for purposes including but not limited to data collection, product display, product offerings, promotional offerings, feedback requests, and other uses in compliance with Canada's Anti Spam Legislation.