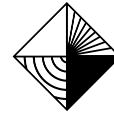


SOLACE HEALTH NETWORK

01

PATIENT CONSULT QUESTIONNAIRE

PATIENT INFO

Gender: Male ☐ Female ☐ Other ☐ Health Card Number: ______________________

First Name: ______________________ Last Name: ______________________

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

Address: ______________________ Suite No.: ______________________

City: ______________________ Province: ______________________ Postal Code: ______________________

Home Phone #: ______________________ Cell #: ______________________ Business #: ______________________ Ext: ________

Consent to Leave Voicemail: Yes ☐ No ☐ Consent to Leave Voicemail: Yes ☐ No ☐ Consent to Leave Voicemail: Yes ☐ No ☐

How did you hear about Solace Health Network? (e.g. Another Patient, Word of Mouth, Physician, Pharmacist, Industry Event, Canna Relief, Online Ads, Instagram, Facebook, Google, JV group, Purearthy)

____

What is the Primary Reason(s) you are seeking treatment with medical cannabis?

____

____

CURRENT MEDICAL CONDITIONS (CHECK ALL THAT APPLY)

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

If any of your current condition(s) is not listed above please enter here:

____

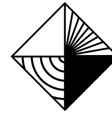
____

Do you have any allergies including previous allergy to cannabis/cannabinoid products? Yes ☐ No ☐ if **YES** please list below

____

____

PATIENT CONSULT QUESTIONNAIRE



SOLACE HEALTH NETWORK

CANNABIS USE EXPERIENCE:

Please select the option that best describes your cannabis use:

No experience ☐ Used in the past ☐ Light to moderate use ☐ Frequent and current use ☐

If you are currently using cannabis please answer the following:

If daily use: How many grams do you use a day? ____________ How many times do you use a day? ____________

If weekly use: How many grams do you use a week? ____________

What method do you use for taking cannabis currently (choose all that apply)?

☐ Smoking
☐ Vaporizing
☐ Edibles (baked goods/foods)
☐ Topical/Creams
☐ Oils

PAST MEDICAL HISTORY:

Do you have a personal history of substance abuse Yes ☐ No ☐

If **YES** please indicate the applicable substance below:

☐ Alcohol Alcohol drinks per week: ____________

☐ Prescription Drugs List Drugs: ____________

☐ Illegal Drugs List Street Drugs: ____________
(not including cannabis)

Do you have any history of mental illness including Schizophrenia, Bipolar, and/or Depression Yes ☐ No ☐

If **YES** please indicate the applicable substance below

____

____

____

____

Please list any other past medical history conditions that you have had? e.g. stroke, infections, surgeries

____

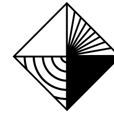
____

____

____

____

____



SOLACE HEALTH
NETWORK

PATIENT CONSULT QUESTIONNAIRE

SOCIAL HISTORY:

The questions below are to help us assess if we may be able to provide assistance with costs associated with cannabis.

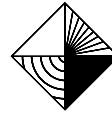
Are you currently employed?	Yes ☐	No ☐
Do you make a salary of less than $30,000?	Yes ☐	No ☐
Have you been in a motor vehicle accident during the last two years?	Yes ☐	No ☐
Are you a Military Veteran that served in the Canadian Armed Forces?	Yes ☐	No ☐
Are you a police officer, first responder (paramedic)?	Yes ☐	No ☐
Do you belong to a union?	Yes ☐	No ☐
Do you have health insurance?	Yes ☐	No ☐

Who is your insurance provider? ______________________________

PLEASE LIST YOUR CURRENT MEDICATIONS:

Medication	Dose/Route/Frequency (i.e. 50 mg by mouth twice daily)	Indication/Reason for Use:

T 1 866 837-7251 F 1 866 837-7291 E info@SHNclinics.ca PO Box 43125 Mississauga ON, L5B 4A7



SOLACE HEALTH NETWORK

PATIENT CONSULT QUESTIONNAIRE

PLEASE LIST YOUR PAST MEDICATIONS:

Medication	Dose/Route/Frequency (i.e. 50 mg by mouth twice daily)	Indication/Reason for Use:

CAGE-AID RISK ASSESSMENT

1. Have you felt that you ought to cut down on your drinking or drug use? Yes ☐ No ☐
2. Have people annoyed you by criticizing your drinking or drug use? Yes ☐ No ☐
3. Have you ever felt bad or guilty about your drinking or drug use? Yes ☐ No ☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover? Yes ☐ No ☐

The Society of Teachers of Family Medicine. Project SAEFP Workshop Materials. Screening and Assessment Module, p. 18.
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