EMERALD LEAF
CANNABIS CLINIC

Emerald Leaf Cannabis Clinic
#105, 6925 Gateway Blvd NW
Edmonton, AB T6H 2J1
Phone: (780) 975-2641
Fax: (587) 469-3317

New Patient Intake Form

Welcome to Emerald Leaf Cannabis Clinic. We are honored to serve you.

Section 1. Patient Information

Full Name First Name _____ Last Name _____

Date of Birth Year _____ Month _____ Day _____ **Email** _____

Home Address Address _____

City _____ Province _____ Postal Code _____

Primary Phone _____ **Can we leave a voice message?** ☐ Yes ☐ No

Alternate Phone _____ **Can we leave a voice message?** ☐ Yes ☐ No

Occupation _____ **Employer** _____

Primary Care Physician _____ **Phone** _____

Referred to Emerald Leaf by _____ **Phone** _____

Section 2. Health History

Medical conditions (symptoms / diagnosis) for which you are requesting (or currently using) medicinal cannabis. Check any that apply to you.

☐ Chronic Pain	☐ Fibro	☐ Cancer	☐ Tremors
☐ Insomnia	☐ Lack of Appetite	☐ Vomiting	☐ Anxiety
☐ PTSD	☐ Arthritis	☐ Addictions / Withdrawal	☐ Lupus
☐ Menstrual Cramps	☐ Crohn's	☐ Post-Concussion	☐ Osteoarthritis
☐ Seizures	☐ ALS	☐ MS	☐ Inflammation
☐ Depression	☐ Glaucoma	☐ Nausea	☐ Joint Pain

☐ Other (Please Describe) _____

List All Current Medications: _____

Other treatment(s) being used to treat condition(s). Check any that apply to you.

☐ Exercise ☐ Massage ☐ Chiropractic ☐ Acupuncture

☐ Physiotherapy ☐ Counselling ☐ Meditation ☐ Diet

☐ Other (Please Describe) _____

Family medical history (parrents / siblings / children). Check any that apply to you.

☐ Heart Condition ☐ Lung Condition ☐ Mental Health Condition ☐ Cancer

☐ Other (Please Describe) _____

Do you currently use any of the following substances?

Cigarettes? ☐ Yes ☐ No If yes, how often? ☐ Daily ☐ Weekly ☐ Rarely

Alcohol? ☐ Yes ☐ No If yes, how often? ☐ Daily ☐ Weekly ☐ Rarely

Recreational Drugs? ☐ Yes ☐ No If yes, how often? ☐ Daily ☐ Weekly ☐ Rarely

Section 3. Cannabis Use

Have you ever used cannabis or cannabis-based products in the past? ☐ Yes ☐ No (Never used)

How often do you currently use cannabis? ☐ Never ☐ Sometimes ☐ Most Days ☐ Every Day

Age when regular use began? Please write N/A if not applicable. ☐ Years Old

Average amount used? Please write N/A if not applicable. ☐ grams/day

Method(s) of consumption used. Check any that apply to you.

☐ Smoking ☐ Vaporising ☐ Oral Ingestion ☐ Topical

☐ Other (Please Describe) _____

Section 4. Cage-Aid Questionnaire

Have you ever felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No

Does it upset you when people criticize your drinking or drug use? ☐ Yes ☐ No

Have you ever felt guilty about your drinking or drug use? ☐ Yes ☐ No

Have you ever had a drink or used drugs to get rid of a hangover? ☐ Yes ☐ No

Do you experience withdrawals when you do not drink or use drugs? ☐ Yes ☐ No

Section 5. General Anxiety Disorder (GAD)

In the past two weeks, how often have these problems bothered you?

Feeling nervous, anxious, or on edge.	☐ Not at all	☐ Several days	☐ Most days	☐ Nearly every day
Not able to stop or control worrying.	☐ Not at all	☐ Several days	☐ Most days	☐ Nearly every day
Trouble relaxing.	☐ Not at all	☐ Several days	☐ Most days	☐ Nearly every day
Restlessness.	☐ Not at all	☐ Several days	☐ Most days	☐ Nearly every day
Becoming easily annoyed or irritable.	☐ Not at all	☐ Several days	☐ Most days	☐ Nearly every day
Afraid something awful mght happen.	☐ Not at all	☐ Several days	☐ Most days	☐ Nearly every day

Section 6. Patient Health Questionnaire

In the past two weeks, how often have these problems bothered you?

Little interest in doing things.	☐ Not at all	☐ Several days	☐ Most days	☐ Nearly every day
Feeling down, depressed, or hopeless.	☐ Not at all	☐ Several days	☐ Most days	☐ Nearly every day
Trouble falling or staying asleep.	☐ Not at all	☐ Several days	☐ Most days	☐ Nearly every day
Sleeping too much.	☐ Not at all	☐ Several days	☐ Most days	☐ Nearly every day
Feeling tired or having little energy.	☐ Not at all	☐ Several days	☐ Most days	☐ Nearly every day
Poor appetite or overeating.	☐ Not at all	☐ Several days	☐ Most days	☐ Nearly every day
Feeling badly about yourself.	☐ Not at all	☐ Several days	☐ Most days	☐ Nearly every day
Trouble concentrating on things.	☐ Not at all	☐ Several days	☐ Most days	☐ Nearly every day
Moving or speaking too slowly.	☐ Not at all	☐ Several days	☐ Most days	☐ Nearly every day
Suicidal thoughts.	☐ Not at all	☐ Several days	☐ Most days	☐ Nearly every day

If you checked off any of the above problems, how difficult has it been to carry out your regular day-to-day?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Section 7. Pain Assessment

Leave section blank if you do not have any pain related issues.

Do you think your pain is a symptom of a more serious issue that has not yet been diagnosed? ☐ Yes ☐ No

Do you believe your pain is treatable / curable? ☐ Yes ☐ No

Do you believe doing physical activities causes further damage? ☐ Yes ☐ No

Is your pain affected by your emotions or stress levels? ☐ Yes ☐ No

Has your pain been: ☐ Getting better ☐ Getting worse ☐ Staying the same

Rate your pain by checking the number that describes your HIGHEST pain over the past week:

None ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Max

Rate your pain by checking the number that describes your AVERAGE pain over the past week:

None ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Max

Check the number that rates the degree to which pain interfered with the following activities:

General Activity

None ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Max

Any specific activity you intended on doing

None ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Max

Mood

None ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Max

Walking ability

None ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Max

Family of household responsibilities

None ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Max

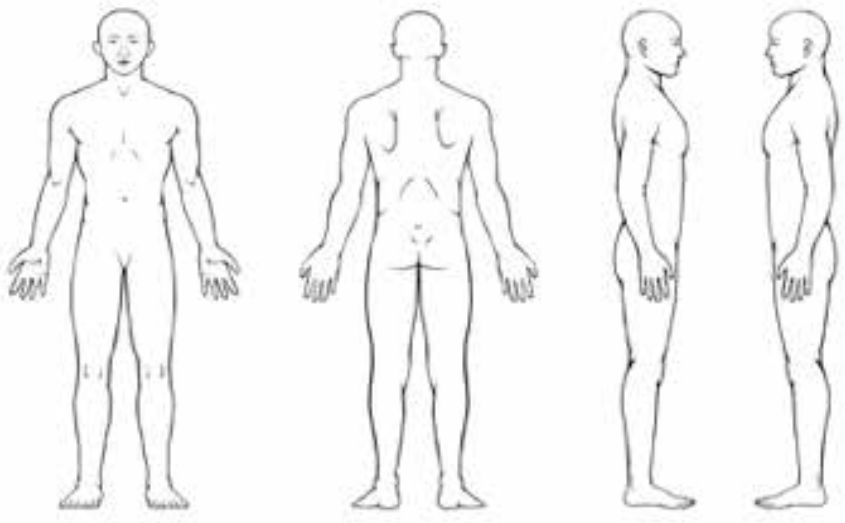
Your work / job

None ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Max

Sleep

None ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Max

On the diagram below, shade the areas your experienced pain over the past week. Draw an "X" on the location experiencing the most intense pain.



Section 8. Patient Consent

Emerald Leaf Cannabis Clinic aims to ensure that each of our patients understand and are informed about the services provided. Including how we collect and disclose personal information ("PI") and Personal Health Information ("PHI" and together with "PI", "Personal information").

Please complete and sign this consent form. By signing this consent form, you will be providing us with your acknowledgment and consent to our collection, use and disclosure of your personal information, as set forth in this consent form.

You may revoke your consent at any time by providing us with a written notice of the withdrawal of your consent. The withdrawal of your consent may render us unable to provide you with our services.

Full Name

First Name _____ Last Name _____

I hereby consent and/or agree to the following personal information practices:

Initials _____ **To the collection, use and disclosure of my personal information for the purpose of providing health care service, clinic operation and payment activities.**

Initials _____ **To my Doctor and Emerald Leaf Cannabis Clinic communicating with me at the following email address:** _____

Initials _____ **To participate in free cannabis counselling and education services offered by Emerald Leaf Cannabis Clinic and Xera One in the event I am given medical documentation for the use of medicinal cannabis. The counselling services include, without limitation: Cannabis Education, consumption, demonstrations, variety selection and guidance, assistance registering with Licenced Producers of my choice, I also consent that Emerald Leaf Cannabis clinic, my doctor, and Xera One, sharing personal information to provide me with counselling.**

Initials _____ **I understand that I am free to withdrawal from the study at any time without having to give a reason. The issue of confidentiality has been explained to me and it has been disclosed to me who will have access to my Personally Identifiable Health Information.**

Initials _____ **I understand that I am free to request registration with any licenced producer authorized by Health Canada.**

Initials _____ **Would you like to be included in future communications or promotions from Emerald Leaf Cannabis Clinic, you may unsubscribe at any time by contacting Emerald Leaf by email or phone, or clicking "Unsubscribe" on the bottom of any newsletter.**

Signature _____ Date _____

Representative Signature (if needed) _____