GREEN VALLEY
WELLNESS

Patient Renewal

Name: _____ **Date of Birth:** _____ **Phone #:** _____

Address: _____ **City/Province:** _____ **Postal Code:** _____

Skype: _____ **Email:** _____

Please circle if any of the following options apply to you:

First Responder Veteran Senior Multiple Sclerosis Cancer CRPS Fibromyalgia

Medical Condition(s) being treated by cannabis: _____

Grams per day: _____ **Would you like to increase grams per day? Yes___ No__**

If "Yes" Why: _____

New Requested Grams per day: _____

Will you be producing your own medicine? Yes___ No ___

Licensed Producer: _____

Would you like to change Licensed Producer? Yes___ No ___

If "Yes" Why? _____

What is your preferred method of consuming medical cannabis? _____

Have you Experienced any adverse reactions to medical cannabis? Yes___ No___

If Yes, please explain: _____

Allergies: _____

Please list any medications you are taking please include dosage as well as method of consumption: _____

_____

Patient Signature: _____ **Date:** _____

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

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

Brief Pain Inventory

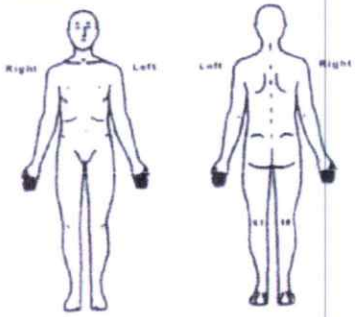
Name: _____ Date:

Time: _____

1. 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*

8. In the past 24 hours, how much relief have 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*

9. 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*

10. In the area where you have pain, do you have "pins and needles", tingling or prickling sensations?

Yes *No*

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

Yes *No*

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

Yes *No*

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

Yes *No*

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

Yes *No*

15. 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 – pins and needles, tingling or burning in the painful area

16. 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 – pins and needles, tingling or burning in the painful area

Modified from McCaffery M, Pasero C: Pain: Clinical manual, p 61, 1999, Mosby, Inc. From Pain Research Group, Department of Neurology, University of Wisconsin-Madison. Bennett MI 2001 PAIN 92:147-157

Patient Health Questionnaire (PHQ-9)

Name: _____ Date: _____

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

For office coding: Total Score _____ = _____ + _____ + _____

Total Score _____

If you 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?

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

Name: _____ Date: _____

Birth Date: _____ Height: _____ Weight: _____