www.wholemedhealth.com

Patient Contact Form

Fax to: 416-245-7633

Applicant's Information

First Name: _____ Last Name: _____ Age: _____

Tel: # _____ Email: _____

Address: _____

City: _____ Postal Code: _____

Date of Birth: _____ Health Card #: _____

Please include two letters if you have the green card.

Gender: Male ☐ Female ☐

What current condition are you seeking to acquire a medical cannabis prescription ?

What current symptom(s) from the condition listed above do you feel cannabis may help alleviate ?

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info@wholemedhealth.com

List all current treatments for the symptom(s) above. This includes all prescription medications, any over the counter treatments, herbal treatments, physio therapy,chiropractor, massage therapy, etc.

Please List Treatments

1. ..... **4.** .....

2. ..... **5.** .....

3. ..... **6.** .....

Have you in the past or are you presently using cannabis to treat your ailments?

How many grams of cannabis are you currently using or have used in the past to treat your ailment(s)

Common Diagnoses for Treatment with Medical Cannabis: Please Mark Below

If you have been diagnosed with any of the following conditions, you are able to speak with a licensed physician about obtaining a medical cannabis document.

***Note: While this is a comprehensive list it is not fully inclusive. Each patient needs to be examined on a case basis, by a licensed and practicing physician, to see whether or not cannabis should be considered for effective treatment.**

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Brain/Head Injury
- ☐ Cancer/Chemo Therapy
- ☐ Chronic Pain
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorders
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Hepatitis C
- ☐ Immune Deficiency Disorder
- ☐ Irritable Bowel Syndrome
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Nausea
- ☐ Neuralgia
- ☐ Psoriasis
- ☐ Seizure Disorders
- ☐ Sleeping Disorders
- ☐ Stress Disorders

A consultation appointment will be scheduled once all the requested information has been received and reviewed

Signature: _____ **Date:** _____

If signed by person(s) other than the noted patient above , state the relationship and authorization to do so:

Patient is: ☐ **Minor** ☐ **Incompetent** ☐ **Disabled** ☐ **Other:** _____

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