PATIENT CONSULT QUESTIONNAIRE

Personal Information

First Name and Last Name

_____

E-mail Address

_____

Date of Birth (dd/mm/yyyy) OHIP Number

Number and Street Address (i.e. 5 Yonge Street, Apt.5)	City	Postal Code

Phone Number (Type – Home, Work, Other)

Emergency Contact Name Relationship Contact Number

_____

Please list recent surgeries, hospitalizations, investigations, consult reports, and any diagnostic imaging

_____

_____

_____

Please list any medication or environmental allergies you have

_____

How did you hear about Kaya Clinics?
Other patients, Word of Mouth, Physician, Pharmacy, Industry Event, kaya Clinics online adds, Facebook, Google.

Other _____

Past Medical History (check all that apply)

Anxiety		Depression		Schizophrenia		Other
Heart Attack		Hypertension		Epilepsy/Seizures		
Stroke		Liver failure/disease		Bipolar disorder		
Asthma		COPD		Neuropathy		
Rheumatoid arthritis		Osteoarthritis		Multiple Sclerosis		
Hepatitis B or C		Hepatitis C		Parkinson's Disease		
Heart Disease (i.e. atrial fibrillatio n, CAD)		HIV/AIDS		Insomnia		
Asthma		Chronic Pain		Inflammatory Bowel		
Disease						

Family History (F = Father, M = Mother)

Cardiovascular Disease (i.e. angina, PVD, CVD, arrhythmias)	☐F	☐M	Mental Health Illness (i.e. psychosis, schizophrenia, bipolar disorder, etc.)	☐F	☐M
Diabetes	☐F	☐M	Alcohol abuse	☐F	☐M
Bleeding Disorders	☐F	☐M	Drug abuse	☐F	☐M
Cancer (Type: _____)	☐F	☐M	Other		
High Blood Pressure	☐F	☐M			
High Cholesterol	☐F	☐M			
Arthritis (Rheumatoid/Osteoarthritis)	☐F	☐M			

Social History

Marital Status	Smoker (YES/NO) Years Smoking: _____ Packs per day: _____	Other
Alcohol (drinks per week)	Street Drugs (Other than Cannabis)	
Exercise	Current or Anticipated Pregnancy	
Caffeine (cups/day)	Employment	

Please list your CURRENT medications and ones you have tried in the PAST for your illnesses

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

What is the **Primary Reason** you are seeking treatment with medical cannabis?

_____

If you are currently using Cannabis, please describe your daily Cannabis usage routine (time of day, method of intake, and amount used each time)?

_____

_____

How has using Cannabis helped your medical conditions?

_____

_____

CAGE-AID Risk Assessment

	YES	NO
1. Have you felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
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?	☐	☐

The Society of Teachers of Family Medicine. Project SAEFP Workshop Materials. Screening and Assessment Module, p. 18. Funded by the Division of Health Professionals, HRSA, DHHS, Contract No. 240-89-0038.

OPIOID RISK TOOL

1. **Family** History of Substance Abuse:	Father	Mother	None
a. Alcohol	☐ 1	☐ 3	☐
a. Prescription Drugs	☐ 2	☐ 3	☐
b. Illegal Drugs	☐ 4	☐ 4	☐
2. **Personal** History of Substance Abuse:	Female	Male	None
a. Alcohol	☐ 3	☐ 3	☐
b. Prescription Drugs	☐ 4	☐ 4	☐
c. Illegal Drugs	☐ 5	☐ 5	☐
3. Age (if you're between 16-45 years old)	☐ 1	☐ 1	☐
4. History of Preadolescent Sexual Abuse	☐ 3	☐ 0	☐
5. Psychological Disease:			☐
a. Attention Deficit Disorder, Obsessive-Compulsive Disorder, Bipolar, Schizophrenia	☐ 2	☐ 2	☐
b. Depression	☐ 1	☐ 1	☐

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk tool. Pain Med. 2005; 6(6):432

For Office Reference:

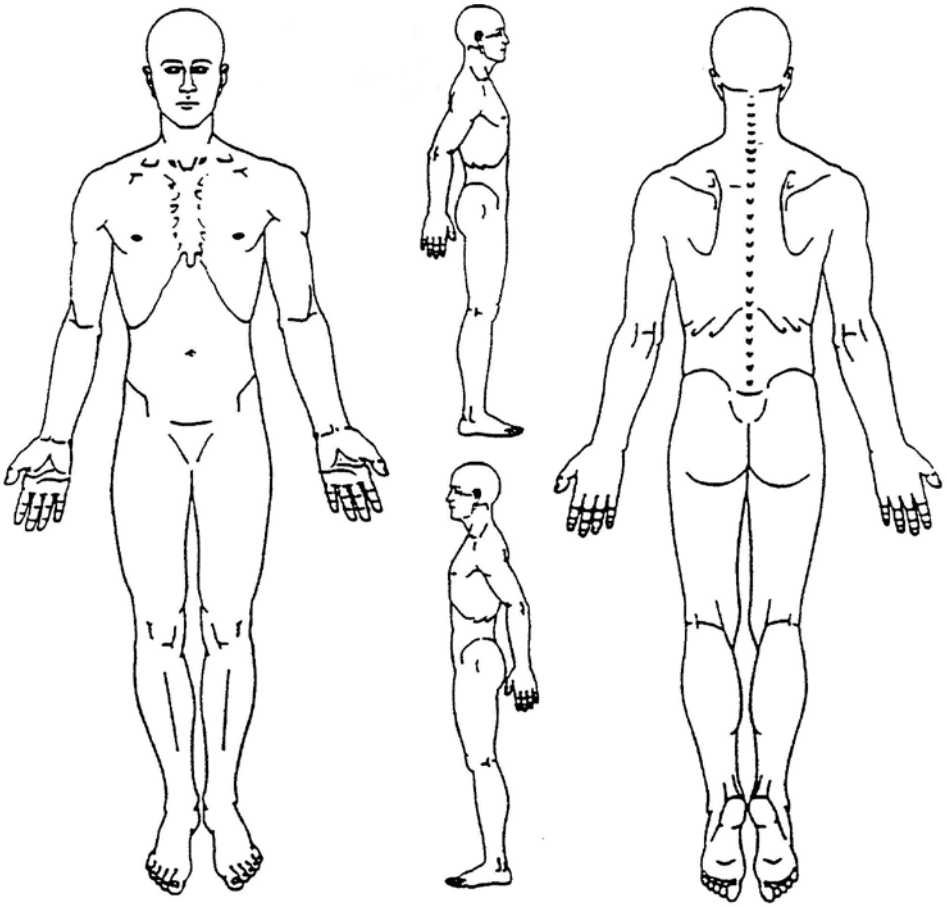
CAGE-AID: Score "0" for No and "1" for Yes → A score of 2 or more is considered clinically significant.

ORT: Low risk = 1-3 | Moderate Risk = 4-7 | High Risk = 8 or more

Brief Pain Inventory – Modified

Instructions: On the diagram below, put an **X** on the areas that hurt the most.

Front **Back**



OFFICE USE ONLY

What makes your pain feel BETTER? **What makes your pain feel** WORSE?

How often does your pain flare up **(i.e. daily, weekly, monthly)?**

_____

_____

_____

_____

_____

Circle the number that describes how, in the **past 24 hours**, pain has interfered with your

General Activity

0 1 2 3 4 5 6 7 8 9 10

No interference Completely Interferes

Mood

0 1 2 3 4 5 6 7 8 9 10

No interference Completely Interferes

Walking ability

0 1 2 3 4 5 6 7 8 9 10

No interference Completely Interferes

Normal work (outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10

No interference Completely Interferes

Relations with other people

0 1 2 3 4 5 6 7 8 9 10

No interference Completely Interferes

Sleep

0 1 2 3 4 5 6 7 8 9 10

No interference Completely Interferes

Enjoyment of Life

0 1 2 3 4 5 6 7 8 9 10

No interference Completely Interferes

(Cleeland CS and Ryan KM. Pain Assessment: Global Use of the Brief Pain Inventory. Ann Acad Med. 1994;23(2):129-38)

Please rate your pain by circling the number that best describes your pain at its WORST in the past 24 hours

No Pain 0 1 2 3 4 5 6 7 8 10 **Worst imaginable pain**

Please rate your pain by circling the number that best describes your pain at its LEAST in the past 24 hours

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst imaginable pain**

Please rate your pain by marking the box beside the number that best describes your pain on AVERAGE

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst imaginable pain**

Please rate your pain by marking the box beside the number that best describes your pain RIGHT NOW

No Pain 1 2 3 4 5 6 7 8 9 10 **Worst imaginable pain**

Rate your Quality of Life

0 1 2 3 4 5 6 7 8 9 10

Not Great **Great**