

# Patient Reassessment Form

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Licensed Producer(s) \_\_\_\_\_ Current Dose Per Day \_\_\_\_\_

Strain (% THC % CBD) \_\_\_\_\_

What form do you most often use?      Edible      Vaporizer      Smoking

Do You Experience any Side Effects?      Yes      No

If Yes Describe \_\_\_\_\_

Since taking cannabis is your condition:      Better      Same      Worse



## Section 1 - Pain

(Complete this ONLY if you are prescribed cannabis for pain relief)

Please Rate Your Pain:

	Best		Worst
At its WORST in the last 24 hours	<input type="radio"/> 1	<input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	<input type="radio"/> 10
At its LEAST in the last 24 hours	<input type="radio"/> 1	<input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	<input type="radio"/> 10
On Average	<input type="radio"/> 1	<input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	<input type="radio"/> 10
At This Moment	<input type="radio"/> 1	<input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	<input type="radio"/> 10

**What treatment or medications are you receiving for your pain?**

\_\_\_\_\_

**Circle the number that best describes how, during the last 24 hours, pain has interfered with your:**

	Does not interfere	Completely interferes
General Activity	0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	<input type="radio"/> 0
Mood	0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	<input type="radio"/> 0
Walking Ability	0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	<input type="radio"/> 0
Normal Work	0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	<input type="radio"/> 0
Relations with Other People	0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	<input type="radio"/> 0
Sleep	0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	<input type="radio"/> 0
Enjoyment of Life	0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	<input type="radio"/> 0
School Work	0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	<input type="radio"/> 0

**In the last 24 hours how much relief have the pain treatments or medications provided? Circle the one number that most shows how much relief you have received**

No Relief      0%      10%      20%      30%      40%      50%      60%      70%      80%      90%      Complete Relief 100%

## How often have you:

	Never	Seldom	Sometimes	Very	Often
Had Mood Swings	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Felt the need for more medication to treat your pain	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Felt impatient with your doctor	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Felt tension at home	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Counted pain pills to see how many are left	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Felt concerned that others will judge you for taking pain medication	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Felt bored	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Taken more pain medication than you were supposed to	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Worried about being left alone	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Felt a craving for medication	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Heard others expressing concern over your use of medications	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Have any of your close friends had problems with drugs or alcohol?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Been told you have a bad temper	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Felt consumed by the need to get more pain medication	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Run out of pain medication early	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Had others keep you from getting what you deserved	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Had legal problems or been arrested (in your lifetime)	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Attended an AA or NA meeting	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Been in an argument that was so out of control someone got hurt	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Been sexually abused	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
How often have others suggested you have a drug/alcohol problem	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Had to borrow pain medications	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Been treated for alcohol or drug problems.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

## Section 2 - Anxiety and Mood Disorders

(Complete this ONLY if you are prescribed Cannabis for Anxiety, Stress, Depression, Sleep disturbances, or other mood disorders)

During the last 2 weeks, how often have you been bothered by the following?

	Not At All	Several Days	More than Half	Nearly Every Day
Feeling nervous, anxious, on edge	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Not being able to stop or control worrying	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Worrying too much about different things	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Trouble relaxing	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Being so restless that it is hard to sit still	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Becoming easily annoyed or irritable	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Feeling afraid as if something awful might happen	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>



**PHQ-9**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Circle the most appropriate number for each.		Not at all	Several Days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
2	Feeling down, depressed, or hopeless	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
3	Trouble falling or staying asleep, or sleeping too much	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
4	Feeling tired or having little energy	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
5	Poor appetite or overeating	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
6	Feeling bad about yourself - or that you are a failure or have let yourself or your family down	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
7	Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
8	Moving or speaking 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.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
9	Thoughts that you would be better off dead or hurting yourself in some way	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
		<b>PHQ9 Total Score:</b>			

**GAD-7**

Over the past 2 weeks, how often have you been bothered by any of the following problems? Circle the most appropriate number for each.		Not at all	Several days	Over half the days	Nearly every day
1	Feeling nervous, anxious, or on edge?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
2	Not being able to stop or control worrying	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
3	Worrying too much about different things	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
4	Trouble relaxing	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
5	Being so restless that it's hard to sit still	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
6	Becoming easily annoyed or irritable	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
7	Feeling afraid	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
		<b>Total score for GAD7:</b>			