OFFICE USE ONLY	Height	Weight	Blood Pressure	Pulse

Name	Date of Birth Age
Primary care physician name and address	Referring physician name and address

Major Complaint:

When did it start and what happened? Describe your symptoms?

Are currently using cannabis to treat your symptoms or pain?

If yes, how much and how often?

Have you had an MRI and/or CT or other testing? Where?

Please circle your pain level on the scale. No pain 1 2 3 4 5 6 7 8 9 10 Intense pain

3600 OLENTANGY RIVER ROAD • SUITE 480 • COLUMBUS, OHIO 43214
COLUMBUSCANNABISCONSULTANTS.COM

614-442-0700
855-453-5002

What have you tried to control your pain? (check boxes below)

☐ Epidural Injections	☐ Spinal Cord Stimulator	☐ Radiofrequency Ablation	☐ Herbal Medications
☐ Physical Therapy	☐ Chiropractic Care	☐ Massage Therapy	☐ Aquatic Therapy
☐ Acupuncture	☐ Joint Injections	☐ Nerve Blocks	☐ TENS Unit
☐ Biofeedback	☐ Counseling	☐ Celebrex	☐ Naprosyn
☐ Relafen	☐ Arthrotec	☐ Daypro	☐ Motrin
☐ Soma	☐ Norflex	☐ Robaxin	☐ Skelaxin
☐ Baclofen	☐ Zanaflex	☐ Valium	☐ Ativan
☐ Xanax	☐ Elavil	☐ Nortriptyline	☐ Trazadone
☐ Paxil	☐ Zoloft	☐ Prozac	☐ Vicoprofen
☐ Percocet	☐ MsContin	☐ Kadian	☐ Oxycontin
☐ Duragesic	☐ Methadone	☐ Neurontin	☐ Topamax
☐ Depakote	☐ Tegretol	☐ Dilantin	☐ Zonegran
☐ Lidoderm	☐ Flector	☐ Cymbalta	☐ Avinza
☐ Lyrica	☐ Tylenol	☐ Advil	☐ Surgery

Other:____

____

Which of those treatments helped? (Please circle)

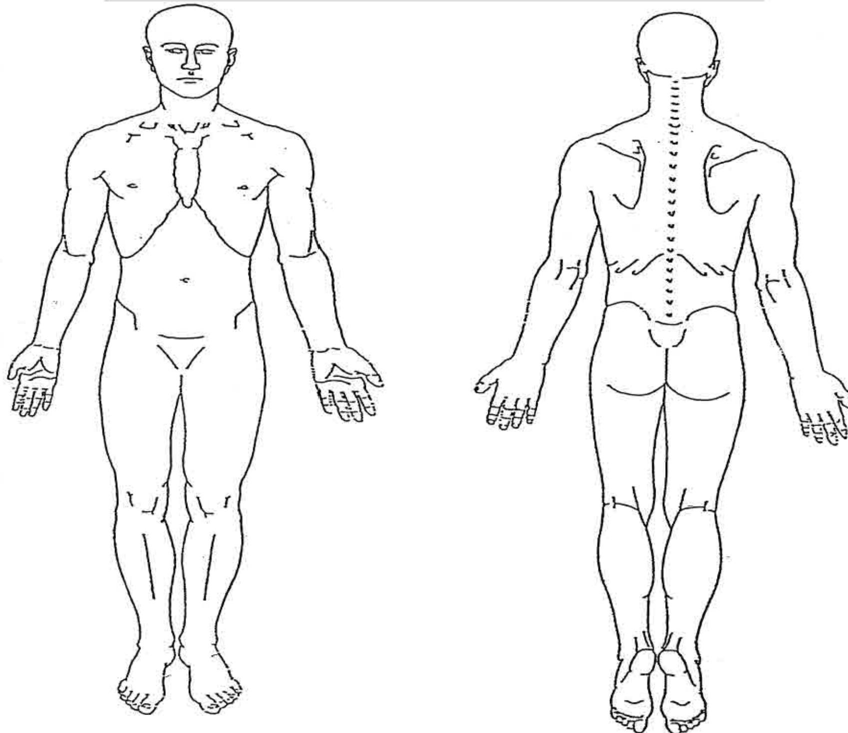
Have you had back or neck surgery?

____

Have you ever been evaluated in a pain clinic? _____
If so, where and by who? ____

____

Please shade in where your pain is located.



What treatments and/or surgeries/procedures have you tried in the past for your qualifying condition?
Please list the physicians who have diagnosed or treated your condition.
Please list your current medications and treatments for your qualifying condition.

Other Current Medications

Name/Dose/Frequency	Reason for taking medication

Medication Allergies

Other Medical Problems

Other Past Surgeries

Social History

☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Widowed

Number of Children:

Education: Occupation: Are you working now?

How much do you drink?

How much do you smoke(tobacco)?

Illicit drug use (i.e., Heroin, Cocaine, Meth)?

Have you ever had a drug overdose?

The information provided above is accurate to the best of my knowledge.

Patient's Signature: ______________________________________ Date: ______________

I have reviewed the information above with the patient.

Physician's Signature: ____________________________________ Date: ______________