Premier Chronic Pain Care **Low THC Oil: Follow-up visit**

Today's Date: _____

Patient Name: _____ **Patient D.O.B.:** _____

Patient's email: _____ **Patient's No:**_____

Patient's diagnosis:

☐ Cancer
☐ Parkinson's disease
☐ ALS (Amyotrophic Lateral Sclerosis)
☐ Tourette's syndrome
☐ Multiple sclerosis
☐ Crohn's disease
☐ Mitochondrial disease
☐ Peripheral Neuropathy
☐ PTSD (Post-traumatic stress disorder)
☐ Seizure disorders
☐ Intractable pain
☐ Sickle cell disease
☐ AIDS
☐ Autism spectrum disorder
☐ Epidermolysis Bullosa
☐ Alzheimer's disease
☐ Hospice

Section A

Are you currently using Low THC Oil? ☐ Yes ☐ No **(If NO, skip to section C)**

What oil concentration are you using _____%

Section B

Please rate your pain improvement: 1 2 3 4 5 **(Where 1 is least and 5 is most)**

Please rate your daily activity improvement: 1 2 3 4 5

Are you using any medications other than Low THC Oil? ☐ Yes ☐ No

(If YES, please list medications you are currently using)

_____

_____

Are you having any adverse effects from the LOW THC Oil? ☐ Yes ☐ No

(If YES, please explain)

_____

_____

_____

Additional treatment response notes **(optional)**:

_____

_____

_____

Section C (Only answer if you responded NO in section A)

Why are you not using Low THC Oil?

☐ No longer interested in Low-THC Oil

☐ Could not obtain Low THC Oil

☐ Using other medications

☐ Other (explain)

_____

_____

_____

Patient or Caregiver Signature: _____ Date: _____

Witness Signature: _____ Date: _____

For Physician ONLY:

How long have you been treating the patient: _____ Years _____ Months

How long since original diagnosis: _____ Years _____ Months