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Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Qualifying Condition(s): \_\_\_\_\_

1. On a scale of 0-7 (0 being "No benefit" and 7 being "A great deal of benefit"), how has Medicinal Cannabis improved your Qualifying Condition(s)? *(please circle the number)*

0	1	2	3	4	5	6	7
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Please Explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Have you had any negative effects from the Medicinal Cannabis? *(please tick all that apply)*

- allergy                       nausea                       vomiting                       intolerance  
 other: \_\_\_\_\_

3. Have you stopped using the Medicinal Cannabis only to experience worsening symptoms of the Qualifying Condition(s)?

- YES                       NO                       Not Applicable

4. How does (or did) Medicinal Cannabis affect your conditions or symptoms overall? *(please tick one only)*

- gives me great relief                       I feel a little worse  
 gives me a little relief                       I feel a lot worse  
 made no difference

5. Did you decrease or discontinue your use of other medicines when you started using Medicinal Cannabis for your condition(s)?

- YES                       NO

6. Have you, or did you, tell any health service providers about your Medicinal Cannabis use?

- YES                       NO

If yes, who and were they supportive? *(please tick all that apply)*

- your GP  
 your specialist  
 nurse  
 psychologist, counselor, or mental health provider

Supportive?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> YES	<input type="checkbox"/> NO