REGISTRATION FORM

1. What is the purpose of your request? Choisissez un élément.

2. Type of request? Choose an item. Choisissez un élément.

3. Identification: RAMQ ☐ Driver licence ☐ Other ☐ _____

4. Daily amount (g/day) do you need? _____

5. First name: _____

6. Name: _____

7. Email: _____

8. # Phone: _____

9. Full address: _____

10. Do you have a criminal record? YES ☐ NO ☐

If yes, is it related to drugs? YES ☐NO ☐

11. Medical Information:

- **# RAMQ: _____**
- **Date of birth:_____**
- **Height: _____**
- **Weight: _____**
- **Family Physician Name: _____**
- **Medical Conditions: _____**
- **Previous Surgeries: _____**
- **Allergies to medications: _____**
- **List of medications:**

_____

_____

- **Do you smoke? _____**
- **Do you drink alcohol? _____**
- **Do you take any drugs, if so:**

_____

- **Do you have chronic pain? _____**
- **Do you have anxiety? _____**
- **Do you have insomnia? _____**
- **Do you have muscle spasms? _____**
- **Do you have nausea and vomiting? _____**
- **Do you have headaches? _____**
- **Do you have a depressive state? _____**
- **Do you have a loss of appetite? _____**
- **Do you have a diagnosis of ADHD? _____**
- **Do you have a diagnosis of bipolarity? _____**

12. Do you need a consultation with a practitioner (Additional fees will apply)?
YES ☐NO ☐

13. Do you wish to have access to a practitioner at all times for follow-up? (Additional fees will apply)
YES ☐ NO ☐

14. Acknowledgment of Health Canada rules and regulations, the undersigned [First and Last Name], acknowledge that I have read and understood all the rules and regulations issued by Health Canada regarding health.

SIGNATURE: _____