



PATIENT INFORMATION

Last Name _____
First Name _____
BirthDate (Y/M/D) _____ Gender _____
OHIP _____ Ver.Code _____
Email _____ Tel _____
Address _____

PHYSICIAN INFORMATION

Physican Signature _____
Physician Name _____
Physician Billing # _____
Tel _____
Fax _____
Address _____

REASON FOR CONSULTATION

Chronic Pain Syndrome

- Arthritis
- Inflammatory Polyarthropathy
- Post Operative/Traumatic
- Fibromyalgia
- Neuropathic _____
- Malignancy _____
- Other _____

Mental Health

- Anxiety/Depression
- PTSD
- Eating Disorder
- ADHD
- Other _____

Neurologic

- Cognitive Impairment
- Seizure Disorder
- Migraines/Headaches
- Multiple Sclerosis
- Parkinson's Disease
- Other _____

Gastrointestinal

- Crohn's Disease
- Ulcerative Colitis
- Irritable Bowel Syndrome
- Other _____

Other

- Insomnia
- Sleep Disordered Breathing
- Appetite Stimulation
- HIV/AIDS

- Recreational User Consultation
for Harm Prevention

Current Medications

- Currently taking Anticoagulants Yes No
- Pregnancy or Family Planning Yes No
- History of Substance Abuse/Addiction Yes No
- History of Psychotic Illness Yes No

RELEVANT MEDICAL HISTORY Please include all relevant test results and consultation notes.

