



### 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.

\_\_\_\_\_  
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