



Date: _____

Medical Cannabis Self-Assessment

Qualifying Condition _____

Symptoms

Check all that apply

- Pain
- Muscle Tension
- Nausea
- Dizziness
- Sleeplessness
- Appetite Loss
- Anxiety
- Other _____

Symptom Severity

1	2	3	4	5	6	7	8	9	10
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Other Medication

Notes

Therapy

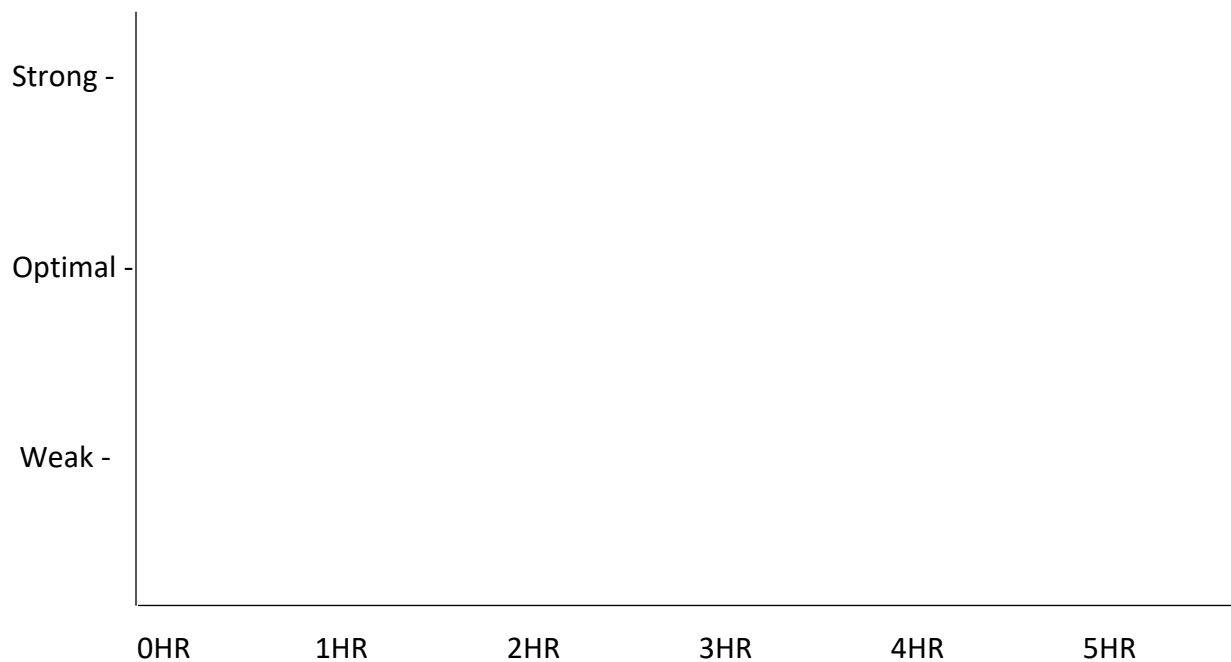
Strain / Product: _____

- Smoked Flower
- Vaped
- Dab
- Ingested
- Applied

Approximate Dosage: _____

Timeline of Effects

Time Consumed: _____



Effects Felt

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> Pain Relief | <input type="checkbox"/> Appetite Stimulate | <input type="checkbox"/> Sedative |
| <input type="checkbox"/> Creative | <input type="checkbox"/> Focused | <input type="checkbox"/> Muscle Relaxation |
| <input type="checkbox"/> Energetic | <input type="checkbox"/> Anti-Depressant | <input type="checkbox"/> Other: _____ |

Negatives Effects

- Dry Mouth
- Anxiety
- Dizziness
- Other_____
- Couch Lock
- Paranoia
- Nausea
- Dry Eyes
- Headache
- Drowsy

Overall Outcome

1	2	3	4	5	6	7	8	9	10
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Much Worse

No Change

Much Better