
**State of New Hampshire Therapeutic Cannabis Program – Patient Intake Survey**

Thank you for agreeing to complete this intake survey on the therapeutic use of cannabis. We are interested in your experiences and attitudes on this issue. The information from this survey will help to improve our knowledge of the extent of therapeutic cannabis use, and the experiences of people who use it for this reason. Please complete the questionnaire by checking the appropriate option, or by writing in the information requested.

The state of New Hampshire takes your privacy extremely seriously.

- Your responses to this intake survey are completely confidential.
- We will ask you to provide your Registry ID number, but we will not match your ID number with any personally identifying information like your name, date of birth, or address.
- You do not have to answer any questions you are not comfortable answering.

If you have any questions about this survey, please contact your Alternative Treatment Center.

Date: _____

Registry ID Number: _____

1. Age: _____ years

2. Gender: ☐ male
   ☐ female

3. Please indicate the qualifying medical condition for which your medical provider has certified you for the therapeutic use of cannabis. (Check all that apply.)

   ☐ Cancer
   ☐ Glaucoma
   ☐ HIV positive
   ☐ AIDS
   ☐ Hepatitis C receiving antiviral treatment
   ☐ Amyotrophic lateral sclerosis (ALS)
   ☐ Muscular dystrophy
   ☐ Crohn's disease
   ☐ Multiple sclerosis
   ☐ Chronic pancreatitis
   ☐ Spinal cord injury or disease
   ☐ Traumatic brain injury
   ☐ Epilepsy
   ☐ Lupus
   ☐ Parkinson's disease
   ☐ Alzheimer's disease
   ☐ One or more injuries that significantly interferes with daily activities

4a. Please list any other **medical** conditions that you have been diagnosed with. *Please note that these do not have to be related to your therapeutic use of cannabis.

_____ _____

_____ _____

_____ _____

4b. Please list any other **psychiatric** conditions that you have been diagnosed with. *Please note that these do not have to be related to your therapeutic use of cannabis.

_____ _____

_____ _____

_____ _____

5. Are there any conditions listed in questions 3 and 4 above for which you are not receiving treatment?

☐ Yes ☐ No If yes, which ones?

_____ _____

_____ _____

_____ _____

6. Please indicate the qualifying symptoms or side effects for which your medical provider has certified you for the therapeutic use of cannabis. (Check all that apply.)

- ☐ Elevated intraocular pressure
- ☐ Cachexia
- ☐ Chemotherapy-induced anorexia
- ☐ Wasting syndrome
- ☐ Agitation of Alzheimer's disease
- ☐ Severe pain
- ☐ Constant or severe nausea
- ☐ Moderate to severe vomiting
- ☐ Seizures
- ☐ Severe, persistent muscle spasms

7. Are there any other symptoms or side effects for which you plan to use therapeutic cannabis.

☐ Yes ☐ No If yes, which ones?

_____ _____

_____ _____

_____ _____

8. Please list your current medications and indicate how effective each one is at alleviating your symptoms. (You may use additional sheets if necessary.)

Medication 1: _____

For what condition: _____

For what symptom: _____

Effectiveness at alleviating your symptom. (Please circle one number.)
(0 means no symptom relief at all; 10 means complete symptom relief.)

0 1 2 3 4 5 6 7 8 9 10

Medication 2: _____

For what condition: _____

For what symptom: _____

Effectiveness at alleviating your symptom. (Please circle one number.)
(0 means no symptom relief at all; 10 means complete symptom relief.)

0 1 2 3 4 5 6 7 8 9 10

Medication 3: _____

For what condition: _____

For what symptom: _____

Effectiveness at alleviating your symptom. (Please circle one number.)
(0 means no symptom relief at all; 10 means complete symptom relief.)

0 1 2 3 4 5 6 7 8 9 10

Medication 4: _____

For what condition: _____

For what symptom: _____

Effectiveness at alleviating your symptom. (Please circle one number.)
(0 means no symptom relief at all; 10 means complete symptom relief.)

0 1 2 3 4 5 6 7 8 9 10

Medication 5: _____

For what condition: _____

For what symptom: _____

Effectiveness at alleviating your symptom. (Please circle one number.)
(0 means no symptom relief at all; 10 means complete symptom relief.)

0 1 2 3 4 5 6 7 8 9 10

9. Please list any cannabis-based medications not listed in question 8 above that you have used but are no longer using and indicate how effective each one was at alleviating your symptoms. (You may use additional sheets if necessary.)

Medication 1: _____

Condition: _____

Symptom: _____

Effectiveness at alleviating your symptom. (Please circle one number.)
(0 means no symptom relief at all; 10 means complete symptom relief.)

0 1 2 3 4 5 6 7 8 9 10

Medication 2: _____

Condition: _____

Symptom: _____

Effectiveness at alleviating your symptom. (Please circle one number.)
(0 means no symptom relief at all; 10 means complete symptom relief.)

0 1 2 3 4 5 6 7 8 9 10

*(You may choose not to answer questions 10 through 10d, but please be assured that if you do your response will remain confidential. This question is not asking about previous or current recreational use of cannabis.)*

10. Have you previously used cannabis to alleviate your conditions/symptoms?

☐ Yes ☐ No (If your answer is "No" or if you choose not to answer, then go to question 11.)

10a. If Yes to question 10, are you currently using cannabis to alleviate your conditions/symptoms?

☐ Yes ☐ No

10b. How effective is or was cannabis at alleviating your conditions/symptoms? (You may use additional sheets if necessary.)

Condition: _____

Symptom: _____

Effectiveness at alleviating your symptom. (Please circle one number.)
(0 means no symptom relief at all; 10 means complete symptom relief.)

0 1 2 3 4 5 6 7 8 9 10

10c. For how long did you use or have you been using cannabis?

☐ Less than 1 month
☐ 1 month – 1year
☐ 1 – 5 years
☐ 6 – 15 years
☐ Longer than 15 years

10d. If you previously used cannabis to alleviate your conditions/symptoms, and have since stopped, why did you stop? (Check all that apply.)

- ☐ It did not work
- ☐ It stopped working
- ☐ I didn't like the side effects
- ☐ Because of its illegal status
- ☐ I was unable to find a supply
- ☐ I was unable to find a regular supply
- ☐ I could not afford it
- ☐ Other (please specify) _____

11. Listed below are a number of effects that people may experience from using various medications or from using cannabis. Please indicate:
    A. Whether you have experienced any of these effects when using either cannabis or other medications for your conditions/symptoms. (Please check all those that apply.)
    B. Whether each of the effects experienced was "good" (+) or "bad" (–).

| **Effect** | **Cannabis** | **+/–** | **Other Medications** | **+/–** |
|---|---|---|---|---|
| Muscle relaxation | | | | |
| Gastro-intestinal irritation/indigestion | | | | |
| Dry mouth | | | | |
| Dehydration | | | | |
| Decreased anxiety | | | | |
| Increased appetite | | | | |
| A feeling of well-being | | | | |
| Constipation | | | | |
| Insomnia | | | | |
| Drowsiness | | | | |
| A depressed feeling | | | | |
| A stimulating feeling | | | | |
| Diarrhea | | | | |
| Difficulty in coordinating movements | | | | |
| Nausea and vomiting | | | | |
| Weight loss | | | | |
| Restlessness | | | | |
| A quicker pulse/palpitations | | | | |
| Headaches | | | | |
| Confusion | | | | |
| Shaking | | | | |
| Sweating | | | | |
| Residual bad taste in mouth | | | | |
| Anxiety | | | | |
| Promotes sleep | | | | |
| Lethargy/lack of energy | | | | |
| Paranoia | | | | |
| Memory loss | | | | |
| Loss of appetite | | | | |
| Peripheral neuropathy (tingling, numbness, burning, cramps or aches) usually in legs, feet, and toes | | | | |