



BEARD BROTHERS SOCIETY
849 Fort Street
Victoria, BC V8W 1E6
250-590-5299



MEMBERSHIP INTAKE APPLICATION

PATIENT INFORMATION

Full Name: _____ DOB: MM / DD / YY

Address: _____

City: _____ Prov: _____ Postal Code: _____

Email: _____

Home Phone: _____ Cell Phone: _____

MEDICAL HISTORY

Medical Conditions and/or Symptoms:

Are you presently taking any prescription pharmaceuticals? (Circle answer) **YES** **NO**

If yes, please list prescribed medications & any side effects:

Continued see reverse

List all *other* treatments used for your medical condition (massage, herbal therapy, exercise or other – specify):

CANNABIS EXPERIENCE

How long have you been using cannabis as a medicine? _____

How does cannabis affect your symptoms?

Is cannabis your primary choice of medication? (Circle answer) **YES** **NO**

What is your preferred method of using marijuana? (Circle all that apply)

Smoking *Vaporizing* *Ingesting* *Topical*

Frequency of use? (Circle answer)

Everyday 1-3 times per week More than once\month Other (specify): _____

How much marijuana do you currently use per day, measured in grams: _____

Please note: The Physician does not sign prescriptions for more than 5 grams per day.

I hereby declare that the information stated above is factual:

Applicants Signature: _____ Date Signed: MM / DD / YY

*****Beard Brothers Society reserves the right to limit medication quantity*****