



**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\*\*\***