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 cannabis? (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 cannabis 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*****