Patient Name:	Date of birth:	Date Completed:
Allergies/Adverse effects to medications:		

1. In order to provide optimal care, it is important for us to maintain an up-to-date list of all your medications.
2. Please fill out the chart below. **If you already have a complete list of your medications, please bring it and we will make a copy in lieu of completing this form.**

Name of prescription medication (brand or generic)	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (by mouth, injection, etc.)
Example: *Lasix*	*20 mg.*	*High blood pressure*	*Two times a day*	*By mouth*

Over the Counter medication or nutritional supplements	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (by mouth, injection, etc.)

Patient updated:	Date:	Patient updated:	Date:
Therapist reviewed:	Date:	Therapist reviewed:	Date: