MEDICATION LIST

NAME_____**DATE**_____

Please list all medications you are currently taking. Include prescription as well as over-the-counter medications.

NAME OF MEDICATION	DOSE	HOW OFTEN DO YOU TAKE	WHAT DOCTOR ORDERED	CHANGE	CHANGE

PATIENT SIGNATURE_____

Date reviewed_____Therapist reviewing_____

Date reviewed_____Therapist reviewing_____

Date reviewed_____Therapist reviewing_____

Revised 02-08