

Name: _____

Date: _____

PLEASE PROVIDE A COMPLETE LIST OF CURRENT MEDICATIONS, INCLUDING DOSAGES

MEDICATION	DOSAGE
PAIN RELIEF MEDICATION	
ANTI-INFLAMMATORY	
HEART/BLOOD PRESSURE MEDICATION	
ANTIDEPRESSANTS /ANXIETY MEDICATION	
OTHER PRESCRIPTION MEDICATIONS	
VITAMINS/OVER THE COUNTER	

Therapist Signature: _____