INTEGRATED THERAPY

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Documentation of Current Medications

Patient Name: ______________________________ Date of Birth: ___/___/_____

Known Allergies: ____

- Please list all medications you are currently taking.
- If you are unsure of your medications, please contact your doctor or obtain a list of your medications from your pharmacist.
- Please be sure to list both prescription and non-prescription (over the counter) medications including herbals, dietary supplements and/or vitamins.

Medication	Dosage	How Often	Method of Delivery by mouth, injection, topically, etc	Reason

Patient Signature: ______________________________ Date: ______________

PLEASE BE SURE TO NOTIFY THERAPIST OF ANY CHANGES IN YOUR MEDICATIONS DURING THE COURSE OF YOUR TREATMENT