



An Associate of Therapy Partners, Inc.

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

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.**

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

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

<b>Patient updated:</b>	<b>Date:</b>	<b>Patient updated:</b>	<b>Date:</b>
<b>Therapist reviewed:</b>	<b>Date:</b>	<b>Therapist reviewed:</b>	<b>Date:</b>