Name: _____ Date: _____ Chart # _____

Primary Care Physician: _____ Phone # _____

Psychiatrist: _____ Phone # _____

Please list ALL **allergies**: _____

_____

_____

_____

Current medications including: prescribed, other-the-counter, herbals, and DIETEARY SUPPLEMENTS

Name	Dose	Date started	Purpose	Any side effects	Office use: Comments