Medication List

Patient Name: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: ­­­­­­­­­­­­­­­­­­­ Date: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medication****(brand, generic name)** | **Dose** | **Frequency of Dosage**  | **Started Taking On** | **Reason for Taking Meds** | **Prescribing Doctor** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |