Medication List

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

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