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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **What I’m taking** | **Form****(pill, injection, liquid, patch, etc.)** | **Dosage** | **How Much** **and When** | **Use: (regularly or occasionally)** | **Start/Stop Dates****Ex: (1/5/05-3/5/05) (1/5/05-ongoing)** | **Notes, Directions, Reasons for Use** |
| 1 |  |  |  |  |  |  |  |
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| 12 |  |  |  |  |  |  |  |

**BE SURE TO INCLUDE ALL PRESCRIPTION DRUGS, OVER-THE-COUNTER DRUGS, VITAMINS AND HERBAL SUPPLEMENTS Therapist reviewed \_\_\_\_\_\_\_\_**