Patient Name:_____ Date:_____

	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							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

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