MEDICATION LIST—INITIAL EVALUATION

Please include ALL prescription, over-the-counter, herbal, and vitamin/mineral/dietary (nutritional) supplements.

MEDICATION NAME	DOSAGE	FREQUENCY	ROUTE (ORAL, TRANSDERMAL, INJECTION, ETC)

I verify that I have reviewed this medication list with the patient.

_____

Therapist Signature Date

I verify that I have reviewed this medication list with my therapist.

_____

Patient Signature Date

PROGRESS EVALUATION—Please list any new medications

MEDICATION NAME	DOSAGE	FREQUENCY	ROUTE (ORAL, TRANSDERMAL, INJECTION, ETC)
Please list any medications you are no longer taking:			

I verify that I have reviewed this medication list with the patient.

_____

Therapist Signature Date

I verify that I have reviewed this medication list with my therapist.

_____

Patient Signature Date