LANCASTER PSYCHOTHERAPY
313 Liberty Street, Suite 223 Lancaster, PA 17603
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MEDICATION AND SUPPLEMENTS

Date ___/___/___ Client's Name _____ Date of Birth ___/___/___

Please list the medications you are currently on

Medication	Dose	Schedule of Dose(s)	Purpose	Prescribed By

Medication Allergies : _____

Please list any dietary supplements you are taking, including vitamins, minerals, herbs and other botanicals, amino acids and enzymes

Supplement	Dose	Schedule of Dose(s)	Purpose

Supplement Allergies: _____

Client's Name _____ DOB ___/___/___

Changes to medication regimen

	Medication Changes				
Date	Stopped	Dose Change	New Medication	Purpose	Prescribed By

Changes to supplement regimen

	Supplement Change			
Date	Stopped	Dose Change	New Supplement	Purpose

_____ ___/___/___ _____ ___/___/___

Client's Signature Date Clinician's Signature Date