In Motion Therapy™

An Associate of Therapy Partners, Inc.

Patient Name:	**Date of birth:**	**Date Completed:**
Allergies/Adverse effects to medications:		

1. In order to provide optimal care it is important for us to maintain an up-to-date list of all your medications.
2. Please fill out the chart below. ****If you already have a complete list of your medications, please bring it and we will make a copy in lieu of completing this form.**

Name of <u>prescription medication</u> (brand or generic)	**Dosage**	**Why are you taking this medication?**	**How often do you take it?**	**How do you take it? (by mouth, injection, etc.)**
Example: *Lasix*	*20 mg.*	*High blood pressure*	*Two times a day*	*By mouth*

<u>Over the Counter medication</u> or <u>nutritional supplements</u>	**Dosage**	**Why are you taking this medication?**	**How often do you take it?**	**How do you take it? (by mouth, injection, etc.)**

Patient updated:	**Date:**		**Patient updated:**	**Date:**
Therapist reviewed:	**Date:**		**Therapist reviewed:**	**Date:**