ALLIED PHYSICAL THERAPY
MEDICATIONS LIST

We are required to have it on file. Thank you!
If you have this information available from another form,
please attach it to this if you wish.

Patient Name_____ Date of Birth_____ Today's Date_____

____ I take no medications, vitamins or supplements.

Name of Medication Include prescriptions, vitamins, herbals, and over-the counter	Dosage	Frequency	Route of Administration

02/2015