

Medication Checklist

Please list all medications in the appropriate category below. Please include dosage and frequency. If you require more space, please ask a front desk staff member for assistance.

Prescription Medication Name	Dosage	Frequency	Route
Over-the-Counter Medication Name	Dosage	Frequency	Route
Herbal Supplement Name	Dosage	Frequency	Route
Vitamin/Mineral Supplement Name	Dosage	Frequency	Route

I verify the above information is correct to the best of my knowledge. Yes No

I understand Dynamic Physical Therapy strongly encourages me to communicate with my primary care physician that I am presently taking all of the medications and dosages listed above. Yes No

Patient or Authorized Representative Signature

Date