MEDICATIONS/SUPPLEMENTS LIST

Date: _____

Name: _____ **Date of Birth**: _____

Known Allergies:

_____

If Female: Last Menstrual Period Date: _____ Completed Menopause Age: _____

Please list current prescription/over-the-counter medications & supplements:

Prescription/Over-the-Counter Medications	***Supplements***

Please check: Are you currently receiving any of the following complementary therapies?

- ☐ **Acupuncture**
- ☐ **Biosound Therapy**
- ☐ **EMDR**
- ☐ **Health Coaching**
- ☐ **Massage**
- ☐ **Dietetic Services**
- ☐ **Occupational Therapy**
- ☐ **Physical Therapy**
- ☐ **Other**