



ON THE GO

PHYSICAL THERAPY

Patient's Name: _____ Date: _____

Please list all your medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements, and the dosage, frequency and administration method for each medication.

Medication	Dosage	Frequency	Method of Administration
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:



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		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
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		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Other:

By my signature below, I certify that the information I have provided above and/or on a separate document is complete, accurate and truthful to the best of my knowledge.

Patient/Legal Guardian Signature: _____ Date _____

Patient/Legal Guardian Name: _____

Reviewed by: _____ Date: _____