ONE POINT PHYSICAL THERAPY

867 Greenwood Ave NE
Atlanta, GA 30306
404-600-4627

MEDICATION LIST

In order for us to serve you better, please list your current prescription and over-the-counter medications and any supplements that are currently being taken.

Patient Name:_____. **Date of Birth:**_____.

Please list the name, dose, frequency, and last dose of each medication.

Info provided by: □Patient □Family □Written List Attached □Other:_____.

Medication	Dose	Frequency	Reason	
Example: *Aspirin*	*325 mg*	*Daily*	*Heart*	*i.e. date discontinued or added*
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Drug allergies, if known:_____.

Reviewed by: _____ Date: _____ Reviewed by: _____ Date: _____.

Reviewed by: _____ Date: _____ Reviewed by: _____ Date: _____.

_____

Patient/Parent/Guardian Signature Date Time

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