Client Name: _____ DOB: _____ Date: _____

Please list below any Medications Prescribed to you or your child (if child is the patient):

Medication	**Person who Prescribed the Medication**	**Dose**	**How often it is taken**	**Date it was First Prescribed**	**Reason for Medication**	**List any Side Effects**

Please list below any "Over the Counter Medications you take or give to your child (if child is the patient):

Medication	**Dose**	**How often it is taken**	**Reason for Medication**	**List any Side Effects**

Please list below any Allergies you or your child may have (if your child is the patient):

Allergy	**Is it a Medication or Non-Medication**