# ENGAGE PHYSICAL THERAPY MEDICATION LIST

| **Patient Name:** | **Date of birth:** | **Date Completed:** |
|---|---|---|
| **Allergies/Adverse effects to medications:** | | |

1. In order to provide optimal care it is important for us to maintain an up-to-date list of all your medications .
2. Please fill out the chart below. ****If you already have a complete list of your medications, please bring it and we will make a copy in lieu of completing this form.**

| **Name of <u>prescription medication</u> (brand or generic)** | **Dosage** | **Why are you taking this medication?** | **How often do you take it?** | **How do you take it? (by mouth, injection, etc.)** |
|---|---|---|---|---|
| ***Example:*** *Lasix* | *20 mg.* | *High blood pressure* | *Two times a day* | *By mouth* |
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| **<u>Over the Counter medication</u> or <u>nutritional supplements</u>** | **Dosage** | **Why are you taking this medication?** | **How often do you take it?** | **How do you take it? (by mouth, injection, etc.)** |
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| **Patient updated:** | **Date:** | | **Patient updated:** | **Date:** |
|---|---|---|---|---|
| **Therapist reviewed:** | **Date:** | | **Therapist reviewed:** | **Date:** |