RIVER PARISH
Physical Therapy & Wellness

Medication List

Patient Name _____ Date _____

Please list all prescription drugs and/or non-prescription medications; including vitamins, nutritional supplements, etc.

NAME OF MEDICATION	DOSAGE (HOW MUCH)	FREQUENCY (HOW OFTEN)	DELIVER (HOW IS IT TAKEN)	WHY (REASON FOR TAKING)

Patient/Guardian Signature _____ Date _____

Therapist Signature _____ Date _____