TRUE NORTH COUNSELING, LLC

Find your inner compass

Medical/Medication Sheet

Client name: _____ Date: _____

Date of Birth: _____ Age: _____

Allergies (food, medication, seasonal, etc.): _____

_____

Medical Conditions: _____

_____

Hospitalizations (Reason and date): _____

_____

Past and current substance use (alcohol, nicotine, marijuana, any other illegal drugs): _____

_____

Please list any other medical information you feel is important: _____

_____

Please list current medications, dosage, prescribing physician and date you started the medication.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

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