
Medication Checklist



Please list all medications in the appropriate category below. Please include dosage and frequency. Please attach additional pages as needed.

Prescription Medication Name	Dosage	Frequency
Over-the-Counter Medication Name	Dosage	Frequency
Vitamin / Mineral Supplement Name	Dosage	Frequency
Herbal Supplement Name	Dosage	Frequency

I verify the above information is correct to the best of my knowledge.

I understand WESTARM Therapy Services strongly encourages me to communicate with my primary care physician that I am presently taking all of the medications and dosages listed above.

Patient or Authorized Representative Signature

Date