MADDEN
PHYSICAL THERAPY
The Results You Want. The Care You Deserve.

Name: _____ Date: _____ Birth Date: _____

CURRENT MEDICATIONS

Please list all medications you are taking which include all prescription, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements

Name of Medication	Dosage/Amount (mg., mL, etc.)	Frequency (how often/day)	Route of Administration (i.e. oral, sublingual, injection or topical)

Additional space provided on reverse --->

Name of Medication	Dosage/Amount (mg., mL, etc.)	Frequency (how often/day)	Route of Administration (i.e. oral, sublingual, injection or topical)