Medications and Therapies Questionnaire

Name:_____Date:_____

A. Please provide information about your current medications:

Name of Medication	Dosage and Frequency	Condition being treated	How long have you taken this medication?

B. Nutritional supplements you are currently taking regularly

Name of supplement, frequency and dosages

C. What other treatments or therapies have you had? Check all that apply.

_____**Physical Therapy**

Reason for therapy?

_____**Chiropractic Care**

Reason for therapy?

_____**Acupuncture**

Reason for therapy?

_____**Massage Therapy**

Reason for therapy?

Trainer Notes:

Please list any other therapies or treatments that you have had or are having to improve your health: