In Touch Physical Therapy

Your Pain Stops Here

Patient Name:	Date of Birth:	Date:
Allergies:		

Name of prescription	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (By mouth, injection, etc.)

Over the Counter medication or nutritional supplement	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (By mouth, injection, etc.)

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