WESTSIDE D A N C E PHYSICAL THERAPY

Attention all Medicare patients,

Please fill out the chart below in regards to any and all supplements you are using and/or taking as specifically as possible. Please include all prescription drugs, over the counter drugs, supplements and vitamins that you take.

If there are any categories that you do not know the specifics of please leave them blank and let your therapist know at your next visit.

If there are ever any changes to the list please let your therapist know as soon as the change happens.

Thank you kindly.

NAME OF DRUG, SUPPLEMENT, VITAMIN, etc.	ROUTE OF ADMINISTRATION (i.e: orally, subcutaneously, eye drops etc.)	DOSE (i.e: 25 mg)	FREQUENCY (i.e: 2 x/day)