

UNIVERSAL MEDICATION FORM

Date forn	n started:/	/			
Name:		Address:	Address:		
Phone N	lumber:				
Birth Da	ite:				
Emerger	ncy Contact/Ph	one Numbers:			
	IMMUNIZ	ZATION RECORD (Record the date/ye	ar of last dose taken, if kn	own)	
Tetanus		Flu Vaccine	Flu Vaccine(s)		
Pneumonia Vaccine		Hepatitis Va	Hepatitis Vaccine		
Other:					
		Allergic To/Describe Rea	ction		
		OU ARE CURRENTLY TAKING erbals (examples: ginseng, gingko). Include m			
Date	Name/Dose	Doctor's Name and Reason for Taking	Comments	Date Stopped	

Some medications may impact your mental health treatment. For coordination of care, it may be necessary for your therapist to contact your prescribing doctor. Attached in this paperwork is a release of information. Please complete it with your physician's name and phone number.