West Des Moines
CENTER FOR
PSYCHOTHERAPY

MEDICATION FORM

Please provide us with a list of your current medications. Note that this form is required by your health insurance provider. You will be asked to complete this form every six months and to update it if changes to your medication regimen take palce during the course of treatment.

ALLERGIES

☐ I have no known allergies.

ALLERGY	ALLERGIC REACTION

OVER-THE-COUNTER MEDICATIONS, SUPPLEMENTS, & HERBS

☐ I do not use any of these medications or products.

MEDICATION OR SUPPLEMENT	DOSE	FREQUENCY	PURPOSE

PRESCRIPTION MEDICATIONS

☐ I am not currently on a prescription regimen.

MEDICATION	DOSE	FREQUENCY	PURPOSE	SIDE EFFECTS

CLIENT SIGNATURE: _____ DATE: _____