



UNIVERSAL MEDICATION FORM

Date form started: ___ / ___ / ___

Name:	Address:
Phone Number:	
Birth Date:	
Emergency Contact/Phone numbers:	

IMMUNIZATION RECORD <small>(Record the date/year of last dose taken, if known)</small>		
TETANUS	FLU VACCINE(S)	
PNEUMONIA VACCINE	HEPATITIS VACCINE	OTHER
Allergic To /Describe Reaction:	Allergic To /Describe Reaction:	

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

DATE	NAME OF MEDICATION / DOSE	Doctor's Name and Reason for Taking	Comment	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.