Healing InSight

ACUPUNCTURE
HERBS
FOOD THERAPY

Medications and Supplements

Name _____ DOB _____ Age _____

Please list all medications (prescription and over-the-counter) and vitamins, supplements, and herbs you are currently taking.

Today's Date	**MEDICATIONS (Rx & OTC)**	Dose	Frequency	Rx	Purpose	Date Started
				☐		
				☐		
				☐		
				☐		
				☐		
				☐		

Today's Date	**VITAMINS, SUPPLEMENTS, & HERBS**	Dose	Frequency	Rx	Purpose	Date Started
				☐		
				☐		
				☐		
				☐		
				☐		
				☐		
				☐		

ALLERGIES: Please list any known allergies to medications, foods, pollens, metals, etc.

_____

_____

_____

OTHER:

I **do / do not** *(circle one)* have a pacemaker.

I **do / do not** *(circle one)* have a bleeding disorder.

Are you or could you be pregnant? **Yes / No**