ASSURANCE COUNSELING, LLC
MEDICATION HISTORY

Client: ______________________________
Name:______________________________

Past Psychiatric Medications

Drug Name	Dosage	Month/Year First Prescribed	Reason For Discontinuing

Current Medications: Prescribed for Physical Health/Herbal Remedies/OTC/Vitamins

Drug Name	Dosage	Condition Being Treated

Current Psychiatric Medications

Drug Name	Dosage	Month/Year 1st Prescribed

______________________________ ______________
Client/Parent/Guardian Signature **Date**

______________________________ ______________
Signature of Staff Completing Form **Date**