DR SHERRI BRUCE REGISTERED PSYCHOLOGIST #1458 INC.

CLIENT MEDICATION LIST

CLIENT NAME: _____ **DATE:** _____

- **Medication:** include both prescription medications and over the counter or herbal medicines
- *Strength:* the dose per tablet (usually in milligrams)
- **Schedule:** the frequency and timing of the medication (for example "one at bedtime"; "one before each of three meals daily"; "when I have panic attacks"; about three tablets per week
- **For:** what is the problem symptom or difficulty being treated?
- **Started:** please indicate the start date of medication

1. Medication: _____ **Strength:** _____

Schedule: _____

For: _____ **Started:** _____

Changed: _____

2. Medication: _____ **Strength:** _____

Schedule: _____

For: _____ **Started:** _____

Changed: _____

3. Medication: _____ **Strength:** _____

Schedule: _____

For: _____ **Started:** _____

Changed: _____

4. Medication: _____ **Strength:** _____

Schedule: _____

For: _____ **Started:** _____

Changed: _____