ADVANCE
Counseling Services, LLC

CLIENT MEDICATION LIST

Name _____ D.O.B. _____

Medications:

1. Dosage
2. Dosage
3. Dosage
4. Dosage
5. Dosage
6. Dosage

Medication Additions/Discontinued from Dr. or Psychiatrist (if applicable)

_____

_____

_____

_____

Dr. or Psychiatrist's Name and Phone Number:

_____