Blackstone Valley Physical Therapy Services, Inc.
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Medication List

Patient Name: _____ Date:_____

Please list all prescription medication, over the counter medication, herbals, or vitamin/dietary supplements you are presently taking.

Medication Name	Dosage	Frequency [Circle which applies]	Route [Circle which applies]
		Once/day / Twice/day Other:	Oral / Injection
		Once/day / Twice/day Other:	Oral / Injection
		Once/day / Twice/day Other:	Oral / Injection
		Once/day / Twice/day Other:	Oral / Injection
		Once/day / Twice/day Other:	Oral / Injection
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