SUBSTANCE INTAKE FORM

Name_____ **Date**_____

Please list any prescription medications you are currently taking:

Medications	Diagnosis
_____	_____
_____	_____
_____	_____

Please list any over-the-counter medications you are currently taking:

Product	Symptom	Quantity & Frequency
_____	_____	_____
_____	_____	_____

Please list any vitamins, supplements, herbs, or homeopathic medicines you are currently taking: (Use other side if needed.)

Product	Symptom	Quantity and Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check the following items which apply to you and indicate the amount used:

❑ Coffee	_____	❑ Artificial Sweetener	_____	❑ Energy Drinks	_____
❑ Tea	_____	❑ Antacids	_____	❑ Alcohol	_____
❑ Soft Drinks	_____	❑ Laxatives	_____	❑ Cigarettes	_____
❑ Diet Soft Drinks	_____	❑ Candy/Sweets	_____	❑ Marijuana or other drugs	_____

How many desserts do you have in an average week? _____

Any history of illicit drug use? _____