SUBSTANCE INTAKE FORM

| Name | | _ | Date | e | |
|-------------------------------------|------------------|---|--------------------------|-----------------------------------|--------|
| Please list any prescri | ption medication | ons you are currently | taking: | | |
| Medications | | | Diagnosis | | |
| | | | | | |
| Please list any over-th | ne-counter med | ications you are curre | ently taking: | | |
| Product | | Symptom | | Quantity & Frequency | |
| (Use other side if need | | | | icines you are currently | taking |
| Product | | Symptom | | Quantity and Frequency | |
| | | | | | |
| | | | | | |
| Check the following its | ems which appl | y to you and indicate | — — — — the amount | used: | |
| Coffee Soft Drinks Diet Soft Drinks | | Artificial Sweetener Antacids Laxatives | _ | Energy Drinks Alcohol Cigarettes | |
| How many desserts d | o you have in a | - | | , | |
| Any history of illicit dru | ıg use? | | | | |