A COUNSELING CENTER, P.C.: Intake Medication Form

Last Name First Name Middle Initial Social Security # Counselor

Emergency Contact Phone Guardian Phone

Psychiatrist Phone Family Doctor Phone

PRESCRIPTION MEDICATIONS: 6 Months Prior To Intake

Medication	Form	Dosage	Frequency	Dates	Purpose	Reason Stopped	Doctor

OVER-THE-COUNTER MEDICATIONS: 6 Months Prior To Intake

Medication	Form	Dosage	Frequency	Dates	Purpose	Reason Stopped	Source

Client’s Signature Date Signed Counselor’s Signature Date Signed

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