## A COUNSELING CENTER, P.C.: Ongoing Medication Form

Last Name First Name		Middle Initial	Social Security #	Counselor	
Emergency Contact		Phone	Guardian	Phone	
Psychiatrist		Phone	Family Doctor	Phone	

## PRESCRIPTION MEDICATIONS: \*\*\*\*SINCE INTAKE ONLY\*\*\*\*

Medication	Form	Dosage	Frequency	Dates	Purpose	Reason Stopped	Doctor
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