



Joel D. Judd, PT, MPT, OCS
Owner/Director

Patients Name: _____ DOB: _____

Please list all prescriptions, over the counter, herbals, and vitamins/mineral/dietary (nutritional) supplements.

Medications/ Supplements	Dosage	Frequency	Route of Administration (example: by mouth/ injection)

Patients Signature: _____

Reviewed by: _____ Date: _____

Scanned: _____