Bunker Hill Physical Therapy
Patient Medication List

The following information is required for Medicare. Please complete to the best of your knowledge. Review if you have any changes, and please update that information.

NAME: ____ DATE: _____/_____/_____

HEIGHT: _____' _____" WEIGHT: _______lbs.

PAIN LEVEL: Please cirlce the word(s) that apply best to the pain you are having.

☐ Cramping	☐ Sharp	☐ Stinging	☐ Severe
☐ Dull	☐ Burning	☐ Deep	☐ Intolerable
☐ Aching	☐ Pressure	☐ Nagging	☐ Throbbing

SELECT YOUR PAIN LEVEL:

NO PAIN										EXTREME
0	1	2	3	4	5	6	7	8	9	10

CIRCLE HOW EACH MED IS TAKEN

MEDICATIONS TAKEN:

			Circle how taken - (T) Topical	(I) Injection	(M) Mouth
________________	Strength _______mg	Dosage _____ x per day	T	I	M
________________	Strength _______mg	Dosage _____ x per day	T	I	M
________________	Strength _______mg	Dosage _____ x per day	T	I	M
________________	Strength _______mg	Dosage _____ x per day	T	I	M
________________	Strength _______mg	Dosage _____ x per day	T	I	M
________________	Strength _______mg	Dosage _____ x per day	T	I	M
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________________	Strength _______mg	Dosage _____ x per day	T	I	M
________________	Strength _______mg	Dosage _____ x per day	T	I	M
________________	Strength _______mg	Dosage _____ x per day	T	I	M
________________	Strength _______mg	Dosage _____ x per day	T	I	M

VITAMINS/SUPPLEMENTS

________________	Strength _______mg	Dosage _____ x per day	T	I	M
________________	Strength _______mg	Dosage _____ x per day	T	I	M
________________	Strength _______mg	Dosage _____ x per day	T	I	M
________________	Strength _______mg	Dosage _____ x per day	T	I	M
________________	Strength _______mg	Dosage _____ x per day	T	I	M

If necessary, list additional medications on the back of this form, or attach a copy of your list of medications.