Please email back completed form to naturopathnicole@gmail.com or bring with you to your visit

# Medication Form

**( Strictly Confidential )**

Full Name: ___________________________________ Today's Date: _________/________/________

Current Pharmaceutical Medication:

| Medication Name: | Strength / Dose: | Frequency: | Reason Prescribed: | For how long: |
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Previous Pharmaceutical Medication:

| Medication Name: | Strength / Dose: | Frequency: | Reason Prescribed: | For how long: |
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Current Nutritional / Herbal Medication:

| Medication Name: | Strength / Dose: | Frequency: | Reason Prescribed: | For how long: |
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Previous Nutritional / Herbal Medication:

| Medication Name: | Strength / Dose: | Frequency: | Reason Prescribed: | For how long: |
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Sign Here: __________________________________________ Office Use Only
Client Number: ____________________

Date : ________/_______/20_______

By signing you agree that the above information is correct. and agree to have personal records kept regarding your health and personal details. You also understand that Nicole Tricarico Naturopath and her staff may used these records to contact you but, at no time will information be divulged with any other third party in any way without your consent.
Thank you for your time, patience and commitment towards assisting us with your health concerns.