Recovery Counseling Center, LLC
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MEDICATION MANAGEMENT

Name: _____ Date: _____

1) Primary care physician name:_____ Phone: _____
Last physical exam date: _____ Issues: _____

2) Allergies:_____

3) Current Medications (name, dose, length of use): _____

_____

_____

4) Presenting Issue(s) and severity:_____

_____

_____

5) Check all that apply:

- ☐ Abdominal pain
- ☐ Bedwetting
- ☐ Blood pressure issues
- ☐ Blurred vision
- ☐ Cancer
- ☐ Convulsions
- ☐ Coordination issues
- ☐ Diabetes
- ☐ Dietary issues
- ☐ Unexplained weight gain
- ☐ Unexplained weight gain
- ☐ Eating disorder
- ☐ Frequent or serious illness
- ☐ Head injury
- ☐ Headaches
- ☐ Hysterical attacks
- ☐ Injuries
- ☐ Insomnia
- ☐ Loss of consciousness
- ☐ Menstrual problems
- ☐ Racing thoughts
- ☐ Nightmares
- ☐ Depression
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Paralysis
- ☐ Ulcer
- ☐ Peptic ulcers
- ☐ Ringing in ears
- ☐ Sexual issues
- ☐ Thyroid issues
- ☐ Uncontrolled crying
- ☐ Nausea
- ☐ Dizziness
- ☐ Fainting spells
- ☐ Other_____

6) Medical History (Surgeries, hospitalizations): _____

_____

7)Have you used drugs or alcohol over the past: week?_____ month?_____ year?_____

8) Any suicidal thoughts over the past: week?_____ month?_____ year?_____

SIGNATURE: _____ DATE: _____