NORTH TEXAS
HEALING CENTER

MEDICATIONS/SUPPLEMENTS DOCUMENTATION FORM

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Please list any prescription medications that you are currently taking:

_____

_____

_____

Please list any over-the-counter medications that you take on a regular basis:

_____

_____

_____

Please list any vitamins or supplements that you are currently taking:

_____

_____

_____

The information above is complete and true to the best of my knowledge.

Signature: _____ Date: _____