

**THE GUIDANCE CENTER
ADULT AND FAMILY SERVICES
MEDICATION HISTORY**

Client Name: _____

Past Psychiatric Medications

Drug Name	Dosage	Month/Year First Prescribed	Reason For Discontinuing

Current Medications: Prescribed for Physical Health/Herbal Remedies/OTC/Vitamins

Drug Name	Dosage	Condition Being Treated

Current Psychiatric Medications

Drug Name	Dosage	Month/Year 1st Prescribed

Client/Parent/Guardian Signature

Date

Signature of Staff Completing Form

Date

Psychiatrist Signature

Date